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Iowa Medicine
JOURNAL OF THE IOWA MEDICAL SOCIETY | JANUARY 1996

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Focus on

Elder Abuse

What is elder abuse and why does it happen? 18

Elder abuse reporting and ethical dilemmas for physicians 20

Community resources to assist victims, caregivers 25

Diagnosing and managing elder abuse 29

STACKS



Late-breaking CHMIS news —
Data repository bids are substantially higher than anticipated — delay sought
See page 11

Managed care — News you can use
Check on page 8 for this brand new *Iowa Medicine* feature!

This month's Managed Care News *looks at practice guidelines*



Check out our track record . . .

In the 1994 elections, IMPAC contributed over $75,000 to 114 candidates running for state office. IMPAC contributed to 105 winners for a 92% success rate. Obviously, contributions from Iowa physicians were used effectively.

But we cannot stop there. The 1996 elections are just around the corner. We cannot afford to let the interest of medicine be overshadowed by the banter of political rhetoric. The strides made by IMPAC in 1994 must be sustained through 1996 if Iowa physicians are to be heard by their lawmakers.

If doctors abdicate responsibility to participate in the political process, it is certain that non-physician groups will take our place. They have already begun their fund-raising and grass roots work for 1996 and we cannot afford to fall behind now.

The time has come to step forward and be heard through a strong IMPAC.

Join IMPAC today!

IMS *DEADLINE* news

JANUARY, 1996

Late-breaking news of interest to Iowa physicians

●**BIG NEWS FOR IOWA PHYSICIANS ON THE CHMIS FRONT** unfolded during the past few weeks. It appears as though the July 1, 1996 deadline for Iowa physicians to comply with requirements of the Community Health Management Information System (CHMIS) will be delayed one year. As you probably already know, the CHMIS law passed by the Iowa Legislature three years ago called for mandatory electronic claims processing and a central data repository containing information taken from HCFA-1500 and UB-92 claim forms. Bids for setting up the data repository received by the CHMIS Governing Board in mid-December were over twice as high as anticipated. The Iowa Legislature anticipated that the CHMIS would be paid for by the participants and allocated no funds to support it. The Governing Board has no idea how to fund the data repository at the level of the current bids. They Governing Board has decided to ask the 1996 Iowa Legislature for an extension of the deadline while they try to decide the future of the CHMIS. Rest assured that the IMS will continue participating in this process to ensure that physician concerns are addressed. Late last month, the IMS sent a mailing to all member physicians notifying them of these important CHMIS developments. Additional details can be found on page 11, or call Ed Whitver of the IMS staff.

●**MEDICARE CODING ERRORS ARE THE FOCUS** of a clampdown which began January 1. Though recent issues of *Iowa Medicine* have contained details, it bears repeating that this initiative is beginning. Medicare carriers plan to run all claims through computerized screens designed to catch physicians who bill for incorrect combinations of services. The screens are programmed to spot over 87,000 incorrect combinations. For more details, call Barb Cannon at the IMS, 800/747-3070.

●**THE *FEDERAL REGISTER* PUBLISHED DECEMBER 8, 1995** contains the 1996 Relative Value Units, conversion factors and discussion of changes to Medicare payment policy. The published information is effective January 1, 1996 although there is a comment period until February 6, 1996. Copies can be ordered from the Government Printing Office for $8. Specify document number 069-001-000 90-4. Credit card orders will be accepted by phone at 202/512-1800. Or, fax in an order to 202/512-2250. For additional assistance, call Barb Cannon at the IMS, 515/223-1401 or 800/747-3070.

●**THE DEPARTMENT OF HUMAN SERVICES** has decided to scuttle a plan to bundle diagnostic lab and ultrasound charges into Medicaid's obstetrical global billing (Physicians Informational Release no. 95-5) without an increase in the global fee. When the plan was announced, IMS staff estimated the services being bundled could total $500. IMS approached the DHS to voice extreme concern on behalf of Iowa physicians and the DHS reevaluated the decision. Physicians will receive a letter of explanation from Unisys – the Medicaid fiscal intermediary – completely rescinding the policy. If you have questions, call Barb Cannon of the IMS staff.

●**THE IMS IS LAUNCHING A PROGRAM** which will help Iowa physicians understand HCFA's new documentation requirements for E & M coding. The program has three components – a series of workshops around the state, a chart scoring service and a video self-study course. Complete details were mailed to all IMS members. The insert in this month's magazine includes a registration form for the workshops.

For more information about any *DEADLINE* news item, call Chris McMahon at IMS headquarters, 515/223-1401 or 800/747-3070.

Iowa Medicine

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About the Cover

This month's cover photo symbolizes the fact that senior citizens can lead productive and creative lives. The photo was taken by Steve O'Brien, a photographer and digital imaging specialist with the Iowa Division of Criminal Investigation.

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Iowa employers say their health care choiees are dietated by the employees' perception of quality. ● *THE PRESIDENT COMMENTS*

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Elder abuse is one of the most misunderstood and under-reported societal problems. Feature articles on pages 18-26 examine the problem and the role physicians can play in solving it. The articles focus on how to recognize elder abuse and neglect, ethical dilemmas, physician reporting responsibilities and community resources available to assist victims and care givers.

● *STANLEY HAUGLAND, MD; GLENYS WILLIAMS, MD; ROY OVERTON, II, MD; DEANNA CLINGAN-FISCHER, JD*

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29 **Diagnosing and managing elder abuse**

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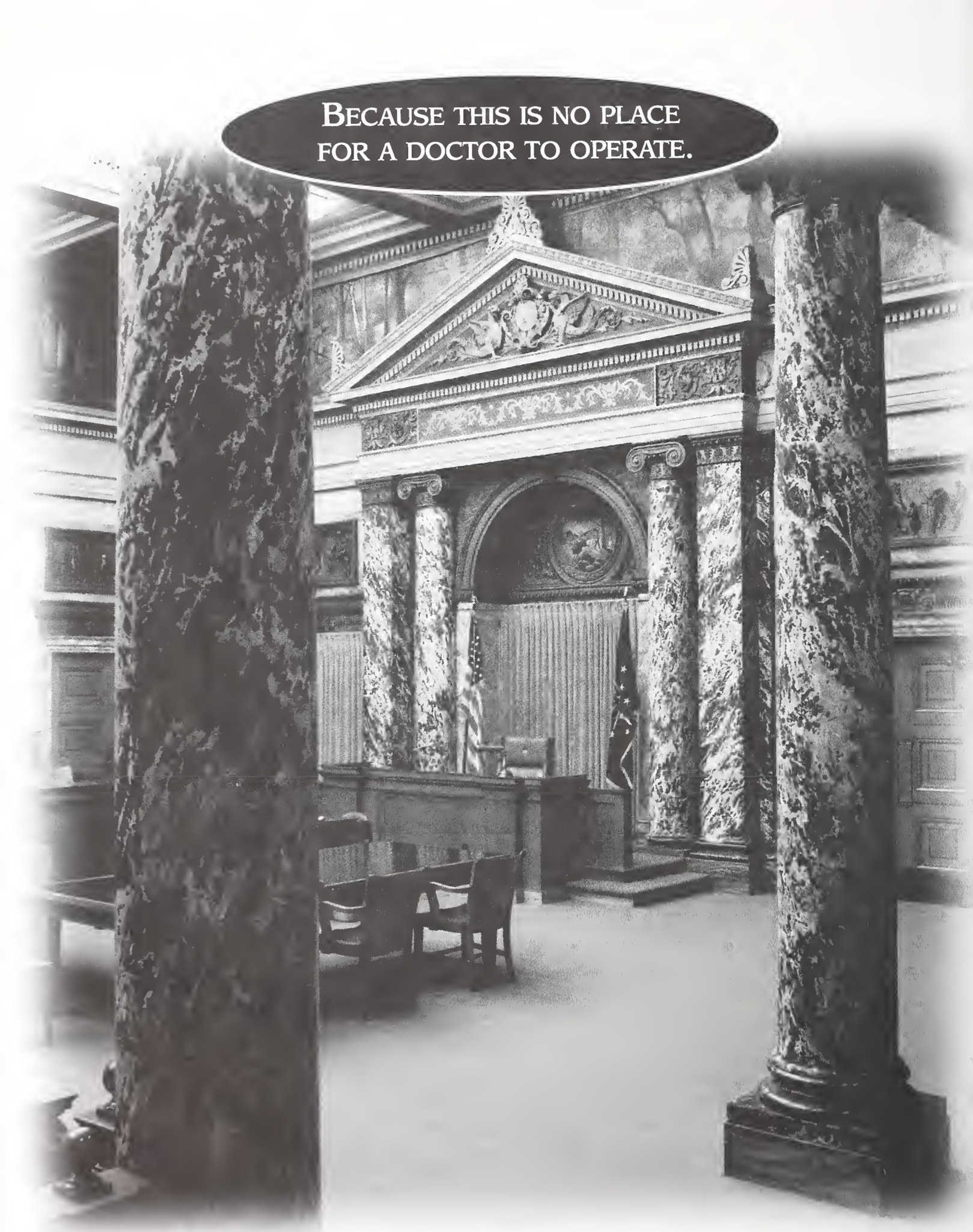
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All articles published in *Iowa Medicine* are listed in *Index Medicus*

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What do employers want?

The IMS Board of Trustees met recently with the Board of Trustees of the Iowa Association of Business and Industry. We asked the ABI leaders what they look for when selecting a health plan for employees. The reply, not unexpectedly, was cost and value (value being loosely translated as quality). Naturally, the next question involved how you determine quality. Their reply was, "Our employees tell us and we listen." Thus, it is the employees impression of care that is very important to the employer. What physicians regard as quality of care may not be the same and may not be as important to the patient. This dichotomy was pointed out in a study done a few years ago by the Picker Institute. They noted that quality in health care has two distinct connotations. One has to do with professional competence, the appropriateness of exams, technical quality of diagnostic and therapeutic procedures, etc. This is appropriately assessed by professional standards.

Their reply was, "Our employees tell us and we listen."

The quality of the patient's experience is another issue. This can be assessed only by the patients themselves and this is what concerns ABI employers.

A Prudential survey of what patients want yielded the following: patients want emotional support, someone who listens to them, eompassion, someone who remembers them by name and someone who gives them a feeling of being cared about. No real surprise here for most physicians I am sure. The survey also revealed that if a patient could talk 46 to 60 seconds without being interrupted, he or she felt they had been listened to. A great return for a small investment of time.

The Picker Institute survey revealed seven broad areas of care that most affected patient's experiences:

1) Respect for patient's values, preferences and expressed needs.

2) Coordination of care and integration of services within an institutional setting.

3) Communication between the patient and providers, dissemination of accurate, timely and appropriate information and education regarding the long-term implications of disease and illness.

4) Physical care, comfort and alleviation of pain.

5) Emotional support and alleviation of fears and anxiety.

6) Involvement of family and friends.

7) Continuity of care during the transition from one locus to another.

Most threatening to patients was the sense of vulnerability and helplessness that illness and hospitalization create and the dependency on others even for help with the most routine activities of daily living.

Help from their doctors in addressing these concerns defines quality care in the eyes of patients and it behooves us as doctors to be aware of this. IM



Joseph Hall, MD

MANAGED CARE

news you can use

Capitation not as prevalent in Minnesota HMOs as believed

Contrary to belief, capitation is not the payment method of choice used by Minnesota HMOs. Alliana Health System, one of Minnesota's mega-HMOs, uses just 21% capitation. Some providers want to capitate to lock in capitation rates based on current utilization, HMOs want to wait until utilization declines further to negotiate more favorable rates.

Federal ruling clears way for Finley-Mercy plan to proceed

A federal judge has ruled that the U.S. Department of Justice failed to prove that a merger between Mercy Health Center and Finley Hospital would create a regional monopoly. According to a recent story in the *Dubuque Telegraph Herald*, the ruling clears the way for the long-delayed merger to take place. The new partnership will be called Dubuque Regional Health Services. In 1993, the two hospitals had combined gross revenues of about $150 million. A spokeswoman for the Justice Department said an appeal is being considered.

Will there be a future role for fee-for-service medicine?

Despite the growth of managed care, the American Medical Association maintains there will always be a role for fee-for-service medicine and the results of a recent survey seem to support that position. The survey of Massachusetts residents showed those with fee-for-service health care were happier than people in HMOs, reported the *Journal of Commerce*. In the survey of 411 people, 93% of those with fee-for-service said they were satisfied; 6% were dissatisfied. Of HMO members, 82% said they were satisfied; 16% were dissatisfied. The survey was conducted by the University of New Hampshire.

Deere clinics set to open this month in Des Moines

Two John Deere Health System clinics under construction for several months will open this month. A facility in Urbandale was built from scratch; the second facility is the old Best Buy building near Merle Hay Mall. Each building had a $1.15 million budget, according to the *Des Moines Business Record*.

How much patient care will managed care eliminate?

The march of managed care, new technologies and alternative settings will prompt a 34% decrease in inpatient hospital days over the five years from 1994 to 1999, according to a new analysis by the Sachs Group. In the same period, discharges could decline by 26% while average length of stay could drop from 6.1 days to 5.5 days. The study predicted that ambulatory facilities will eliminate many surgical inpatient days, with orthopedics dropping 38% and general surgery down 15%. The use of birthing centers will increase and many new mothers and healthy newborns will be in the hospital for stays averaging 12 hours that won't count as discharges.



A guideline by any other name

They're being called by many different names — practice parameters, utilization guidelines, protocols, "best" practices or care management criteria.

No matter what euphemism you choose, they are practice guidelines and their major purpose is to manage cost. Such guidelines are becoming more prevalent in discussions of health care reform and managed care.

Practice guidelines are being used in a variety of ways: to reduce liability risk, to assess quality, to guide case decision-making. Perhaps the most apparent to physicians is the use of guidelines to make admission, discharge and continuing stay decisions. The press is full of examples where medical judgment and managed care guidelines clash.

Practice guidelines will be a source of conflict as physicians advocate for medically necessary care and services while managed care entities assert cost management.

Physician input, discussion and participation in determining guidelines and adequate time for education and assimilation into practice routines are key elements for successful implementation of guidelines.

Do guidelines affect physician behavior?

Many important issues remain unresolved. For example, do practice guidelines affect physician decisions? An article in the November 16 issue of *JAMA* reports on the effect of utilization review on physician behavior. The article concluded that both actual review and sham review may have decreased physician use of hospital services.

Do guidelines consider quality issues? How do guidelines affect access to care? Should guidelines be public or held by private firms?

Trying to balance medical judgment and practice guidelines can place physicians in an ethical dilemma. Ultimately, the physician is liable for patient care and nothing should override medical judgment. Yet, patient relationships are strained when services are not paid. Grievance procedures may be time-consuming. Add to this the pressure of financial incentives for reducing costs.

Recent court cases have set a precedent regarding adverse managed care decisions — that the physician who does not protest a managed care organization decision that is contrary to the physician's medical judgment risks liability exposure.

Brand new ethical issues

In this dawning era of managed care, physicians are struggling with ethical issues unheard of just a decade ago.

In a recent article in *LACMA Physician*, experts listed the following as the top five ethical issues inherent in managed care:

1. Maintaining clinical autonomy; **2.** delivering different standards of care based on a patient's payer; **3.** informed consent and sharing of information; **4.** incentives for underutilization; **5.** limitations on services.

Change is inevitable and practice guidelines will be part of that change. However, it is essential for physicians to pay attention to guidelines as they are being developed and implemented and to participate in ongoing evaluation of the guidelines.

AMA policy states that all practice guidelines should be developed with the involvement of relevant physician organizations and with mechanisms to monitor their use.

MANAGED CARE RESOURCES AVAILABLE FROM IMS

WRITTEN MATERIALS

Colloquium Report on Legal Issues Related to Clinical Practice Guidelines — Legal perspective on 'cookbook' medicine

Two Perspectives on the Ethical Dilemmas in Managed Care Organizations — Ethics of rationing health care, an AMA publication

The Physician and Managed Care — A discussion of how managed care plans operate and how to adapt your practice

Implementing Practice Parameters on the Local/State/Regional Level — This AMA pamphlet is a step-by-step guide

CASSETTES

Physician Rights in Managed Care — AMA Doctors Resource Service

Medical Ethics and Financial Incentives — AMA Doctors Resource Service

VIDEOTAPES

Physician's Update on Managed Care — AMA's Video Journal

Managed Care: An Overview — AMA Doctors Resource Service

The IMS has a comprehensive lending library of managed care materials including articles, booklets and audio and videotapes. Call Sherry at IMS headquarters, 515/223-1401 or 800/747-3070, for more information.

IMS Update

IMS Annual Meeting April 20-21

The 1996 IMS House of Delegates and Seientific Session will be Friday-Sunday, April 19-21 at the Embassy Suites in Des Moines. Make your room reservations by ealling the Embassy Suites at 515/244-1700.

The House of Delegates meets Saturday at 8:30 a.m. and Sunday at 10 a.m. 1996 offiees up for eleetion inelude president-eleet; viee president; trustee; House speaker and viee speaker; three AMA delegates; one AMA alternate; Judieial Counellors in Distriets 2, 4, 5, 10, 11 and 14.

Award nominees sought by IMS

The IMS is seeking nominees for its Physieian Award for Community Serviee and the 1996 Outstanding Iowa Medical Office Administrator Award. The awards will be presented at the 1996 House of Delegates.

The Physician Award for Community Serviee honors an Iowa physieian who has provided outstanding eivie, charitable and health services. The serviees should be uneompensated. The deadline is Mareh 1.

Anyone can nominate a physician by writing to Dean Gillaspey at the IMS. The recipient will be chosen by the Board of Trustees.

The Outstanding Iowa Medical Office Administrator Award reeipient will be chosen by a eommittee of Iowa Medical Group Management Assoeiation members and will also be presented at the House of Delegates.

To nominate a manager for this award, eall Dana Petrowsky at IMS Services, 515/223-2816 or 800/728-5398. IM

AT A GLANCE

The AMA has distributed guidelines on diagnosing and treating alcoholism in the elderly to 110,000 primary care physicains. The AMA says alcoholism in the elderly is often missed, with the problem identified in only 22 to 37% of cases. The guidelines are entitled "Alcoholism in the Elderly: Diagnosis, Treatment, Prevention".

Cheri Jensen has joined the IMS staff in the position of meeting planning coordinator.

Focus on IMS Alliance

On January 17, 1996, the IMS Alliance will cosponsor a seminar entitled "Political Survival Skills". Other sponsors are the IMS and the Iowa Medical Group Management Association.

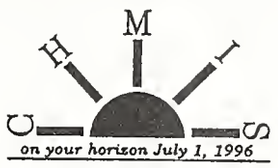
Guest speaker will be Michael Dunn of Dunn and Associates, a Washington, DC consulting firm. Topics will include the role of grass roots action, understanding the legislative process and key issues facing medicine.

The seminar will be held at IMS headquarters and registration will begin at 12 noon. A box lunch will be provided. Registration fee is $25. To preregister, call Sandy Nichols at the IMS.

Contributed by Linda Miller, president, IMSA

Iowa Medical Society 1996 District Caucuses

Dist.	Date	Location and Time	Councilor
1	1/31	Pzazz, Burlington, 6:30 pm	Robert Kent, MD
2	2/7	Highlander, Iowa City (after business mtg)	Jamal Hoballah, MD
3	1/24	Apple River City Cafe, Davenport, 6 pm	Eugene Kerns, MD
4	2/13	Mercy Hosp Educ Ctr, CR, 6:30 pm	Albert Coates, MD
5	1/23	Midway Hoffman House, Dubuque, 6:30 pm	Ross Madden, MD
6	2/13	Prime and Wine, Mason City, 6:30 pm	John Justin, MD
7	2/6	After joint staff meeting	Steven Erickson, MD
8	1/11	Steak Center in State Center, 6 pm	Leo Milleman, MD
9	2/6	Ottumwa Country Club, 6:30 pm	Jay Heitsman, MD
10/11	1/18	Glen Oaks, West Des Moines, 5 pm	Michael Disbro, MD C. David Smith, MD
12	2/5	Lake Shore Ctry Club, Council Bluffs, 6 pm	John Fernandez, MD
13	1/8	Stewart Memorial Hosp, Lake City, 7 pm	Linda Iler, MD
14	1/11	Minervas Restaurant, Okoboji, 7 pm	Stephen Richards, DO
15	2/6	Sioux City Country Club, 6 pm	Kathryn Opheim, MD



CHMIS Update

This page is part of the Iowa Medical Society's ongoing effort to educate Iowa physicians about the Community Health Management Information System (CHMIS).

CHMIS DATA REPOSITORY BIDS

The CHMIS Governing Board has received four bids in response to the Request for Proposals (RFP) from companies interested in becoming the data repository. Bids were received from IBM, the Iowa Foundation for Medical Care, National Computer Systems and Shared Medical Systems.

A committee has been established to review the bids and will make a recommendation to the Governing Board at its December 15, 1995 meeting. It is anticipated the Governing Board will review the contract at that time.

Awarding the contract for the data repository will influence many future decisions on how CHMIS evolves, especially how the CHMIS will be financed.

CHMIS PRIORITIES

The CHMIS Governing Board has developed the following list of goals to accomplish during 1996 and will prioritize this list in December.

- Ensure that all networks operating in Iowa will be able to communicate with other Iowa networks and accept all payer claims.
- Ensure that all networks comply with Iowa network certification rules.
- Develop a plan to implement eligibility, remittance advice and supplemental information as a part of the Iowa CHMIS.
- Ensure that all hospitals will be submitting standardized claims data elements in the American National Standard Institute format.
- Ensure that pharmacy networks will submit the agreed-to subset of outpatient pharmacy claims.
- Identify the vendor partner for the CHMIS data repository.
- Develop a plan to administer patient satisfaction/health surveys.
- Identify additional provider groups to join the system and develop a timeline for their participation.
- Deal with transfer of data between the Iowa Health Data Commission and CHMIS.
- Develop a financing plan and fee structure.

LATE-BREAKING CHMIS NEWS — GOVERNING BOARD SEEKS ONE-YEAR DELAY

At a meeting of the CHMIS Governing Board December 15, IMS representatives learned that funding the data repository component of the CHMIS will be much more difficult than anticipated. The CHMIS Governing Board received four bids on the repository. Two bids were discarded for not meeting the criteria and the remaining two bids are more than double the amount projected by the CHMIS Governing Board.

When the Iowa Legislature passed the CHMIS bill — which mandates electronic claims submission and a central data repository containing information collected from claim forms — no funding was provided. The CHMIS Governing Board expected to fund the data repository through a two-cent per claim surcharge; an 18-cent per-claim surcharge could be required to fund the data repository bids received in December.

The CHMIS Board will ask the Iowa Legislature for a one-year delay in implementing CHMIS, which was originally scheduled for implementation for Iowa physicians on July 1, 1996. A task force will be appointed to study the Board's options.

Since the Iowa CHMIS was first proposed, IMS representatives and IMS members have continually raised concerns about the proposed data repository, particularly the issue of patient confidentiality.

YOUR representatives on state CHMIS committees:

CHMIS Governing Board:

Dale Andringa, MD
Des Moines
515/241-4102

Beth Bruening, MD
Sioux City
712/233-1529

CHMIS advisory committees:

Communications/ Education
Laine Dvorak, MD
Clarence Denser, Jr., MD

Data Advisory
John Brinkman, MD

Ethics/Confidentiality
Charles Jons, MD

Quality Review
Elie Saikaly, MD
William Langley, MD

Technical Advisory
Mark Purtle, MD

IMS CHMIS Committee:

Terrence Briggs, MD (chair)

IMS staff:
Barb Heck
Ed Whitver
Dean Gillaspey

Legislative Affairs

Legislative committee meets with payers

The Iowa Legislature convenes on January 8 and the IMS Committee on Legislation has finalized priorities for the 1996 session.

In addition to priorities reported in the December *Iowa Medicine*, the committee has added a priority of the Iowa Chapter of the American College of Emergency Physicians. The IMS will support legislation to provide enhanced penalties for assaults on health care workers in hospitals. Health care workers are increasingly subject to violence in hospital emergency rooms. It is hoped that enhanced penalties will deter these assaults.

The committee invited representatives of third party payer organizations to attend the meeting and discuss the issue of postpartum hospital stays. Representatives of John Deere Health Plans, Blue Cross Blue Shield and Principal Health Care presented their company's policies on hospital length of stays.

While policies differ between payers, all voiced opposition to legislative intervention in the issue. The IMS will continue to discuss this issue with third party payers, legislators and other interested groups and individuals in preparation for the legislation session.

While the IMS has long opposed legislative mandates, the IMS is concerned about insufficient medical consultation on these kinds of issues. Several legislators have requested that bills be drafted to address this issue.

The IMS, Iowa Medical Group Management Association (IMGMA) and Polk County Medical Society are working with third party payers to develop a uniform credentialing form for use by managed care organizations. Development of a universal form would significantly decrease the administrative burden placed on physician offices as physicians join new managed care networks or are recredentialed for existing networks.

Contact Beeky Roorda of the IMS staff for more information on these and other legislative issues.

AT A GLANCE

As of press time, hearings were being held in Washington on a bill that would establish uniform federal rules for the use and disclosure of patient medical records. The Medical Records Confidentiality Act would specify who may see medical records and under what circumstances.

Several major newspapers reported that Medicare's 37 million beneficiaries will not feel the effects of the GOP budget-balancing bill, if it becomes law.

Congressional auditors recently disclosed that the price tag for Hillary Clinton's health care task force was nearly $14 million. The task force attempting to overhaul our health care system was originally projected to cost less than $100,000.

IMS leaders meet with lawmakers

Iowa physicians attending the AMA Interim Meeting in Washington, DC were among those using the meeting as an opportunity to discuss Medicare reform with Iowa congressmen. The timing of the meeting was crucial since it fell during the last two weeks before required action on the budget.

During round two of the Medicare reform battle, the AMA pledged to fight for four outstanding Medicare issues — antitrust reform for Provider Sponsored Organizations; CLIA reform; medical liability reform; medical savings accounts; and the $350 floor for capitated Medicare payment.

A memorandum from the AMA government affairs staff asked that physicians take the time to thank members of Congress who went "above and beyond" during the first round of the Medicare debate. Rep. Greg Ganske was on the list of those mentioned. IMS leaders expressed appreciation to Rep. Ganske on behalf of organized medicine.

As of press time, Congress remained deadlocked over the key issues of tax cuts, Medicaid, Medicare and other nondefense spending. IM

CONTACTING YOUR LEGISLATORS

Telephone number during the session:

Senators	**515/281-3371**
Representatives	**515/281-3221**
Governor	**515/281-5211**

Write to them at:
STATEHOUSE
Des Moines, Iowa 50319

You may also contact your legislators at home when the legislature is not in session. If you don't know who your legislator is or need your legislator's home address and phone number, call Lyn Durante of the IMS staff, 800/747-3070 or 515/223-1401.

Medical Economics

Preauthorization required by CHAMPUS

CHAMPUS wants to remind physicians that preauthorizations are required for the following procedures when performed on an inpatient basis — abortion, hysterectomy, Cesarean section. This requirement has been in effect since May of 1992.

In Iowa, preauthorization of these cases can be obtained by calling PRO-West at 800/783-2477. Phones are staffed from 5:00 a.m. to 5:00 p.m., Monday-Friday. You may fax your preauthorization request to 800/431-2565.

Authorization must be obtained not more than 30 days and not less than two working days prior to the admission or procedure. If the admission or surgery is urgent, providers have up to two working days afterward to obtain authorization.

MGMA expands member board

The Medical Group Management Association has agreed to expand its 14 member board in 1996 to include two non-voting physician members.

MGMA has campaigned throughout the year to educate the administrator-dominated group about the importance of physician input in board debates.

Insurers expect boost from GOP plan

Medicare reform has the health insurance industry gearing up for a huge increase in business. GOP proposals to encourage more Medicare beneficiaries to enroll in managed care plans could triple insurers' share of the health care market, from 8% to 24%.

If the GOP plan passes, this could translate into an enormous revenue increase for insurers. By the year 2002, they would handle a projected $70 billion in Medicare business annually, compared to $15 billion today.

In anticipation of this boost, Blue Cross and Blue Shield plans in several states are making plans to aggressively market their Medicare managed care products.

The GOP legislation gives the elderly an incentive to join managed care plans — it eliminates the need for Medigap policies that cover costs not included in Medicare.

Critics say there will be little to prevent managed care plans from discouraging high-cost patients from joining; insurers say that Republicans are going to require HMOs to take all comers. The Republican plan will also make it easier for physicians to form their own provider networks.

Handbook for older Iowans

A legal information and resource guide produced by the Young Lawyers Division of the Iowa State Bar Association is now available. The booklet gives legal information on a number of topics of interest to the elderly and also lists programs and resources for elderly services.

The booklet includes information on living wills, power of attorney, trusts, funeral laws, consumer protection and age discrimination.

To get a copy, write to the Young Lawyers Division, Committee on the Delivery of Services to the Elderly, Iowa State Bar Association, 513 East Locust Street, Des Moines, IA 50309-1939.

Cost of premiums slowing

The *Chicago Sun Times* recently reported on a new study showing that the cost of monthly premiums for health insurance is slowing around the country.

However, Midwesterners still pay the most in premiums for health maintenance organizations and preferred provider organizations. HMO premiums in Illinois rose 3.4% in 1995, compared to the national average of 1%. IM

AT A GLANCE

Experts predict that by 1998, HMOs will cover 80% of all employees, up from 65% now. In the short term, this means lower premium hikes for most employers. However, costs may jump again later.

According to a study reported in JAMA, physicians often misunderstand or ignore patients' last requests, resulting in large numbers of people who die alone, in pain and hooked to artificial life support. The article reports that advance directives were recognized in only about 25% of hospital admissions. Physicians — especially those in primary care — have a special role to play in encouraging the use of advance directives, the article concluded.

Practice Management

AT A GLANCE

A seminar entitled "1996 CPT Update & PPR — Year Five" will be presented January 10 at IMS headquarters. The seminar, for physicians and key staff, will be taught by Barbara Cannon, IMS director of medical economics.

"Using HCFA's E & M Documentation Guidelines and Audit Score Sheets" is the topic of a second seminar scheduled to be presented in four locations around Iowa later this month. The evening seminar will be presented January 22, 23, 24 and 25 in Cedar Rapids, Des Moines, Omaha and Sioux City, respectively. The seminar will be taught by Barb Cannon of the IMS staff and Mike Reiling of Partners Consulting Group. For more information on these seminars, check the insert in this issue.

"GB" replaces "ZS"

Effective January 1, the HCFA modifier — "GB" should be added to CPT service or procedure codes to indicate that two or more services or procedures peformed on the same day were separate and distinct.

This replaces the local modifier —"ZS". Physicians are advised to continue using CPT modifier — ZS on E & M service codes to indicate the E & M serivce was separately identifiable.

Incorrect answer in *Part B News*

The November 13, 1995 "Special Report" of Part B News included an answer to a question on coding which is not correct for billing Iowa Medicare claims.

Question #4 stated that a patient's primary care physician cannot use a consultation code to bill for the evaluation of their established patient for a surgeon prior to surgery. This is not correct for Iowa Medicare billing.

The June, 1993 Medicare Info addresses this issue and states that consultation codes are appropriate as long as the criteria for a consultation are met (Physician A asks Physician B for an opinion on a specific problem and Physician B responds.)

Either office or inpatient consultation codes are appropriate, depending on where the service was performed.

Advice on coding phone calls to patients

In a recent article in a specialty society newsletter, a consultant suggested that physicians may choose E & M visit codes which are one level higher to compensate for telephone calls to patients and review of lab results between visits. This advice is very misleading.

The E & M code must be selected based on the documented services performed on the day you see the patient. IM

Midwest Medical Insurance Company Focus on Risk Management

A case of communication breakdown

A patient was examined by her physician for complaints of a lump in her breast. A mammogram identified a suspicious lesion near the right nipple. She was referred to a surgeon, but no clinical information was provided to the surgeon.

The surgeon attempted to aspirate a lump on the far side of the right breast. In a report to her physician, the surgeon said he was unable to obtain any fluid and believed all findings to be normal. The surgeon described the areas he had palpated and aspirated. The areas he described were different from the area of suspicion on the mammogram.

The physician did not notice the discrepancy and advised the patient that findings were normal. He told her to have a repeat mammogram in the near future, but she did not follow through. One year later, she was diagnosed with carcinoma of the right breast. Significant lymph node metastases were present and a malpractice claim was filed.

This case illustrates a frequent cause of claims — a breakdown in communication between physicians. Inadequate communication between providers can result in failure to follow up on potentially serious conditions, the prescription of contraindicated medications or confusion about who is responsible when problems arise. Managed care may have an impact on the quality of communication as physicians are less likely to know or have worked with each other.

To minimize the risk of patient injury:

- Provide consultants with adequate clinical information.
- Spell out responsibility for follow-up care.
- Complete written reports to referring physicians in a timely manner.

For further information, eontaet Lori Atkinson, MMIC risk management supervisor, MMIC West Des Moines offiee, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.

Sponsored by IMS Services

1996 CPT Update and PPR — Year Five

Date:	**Wednesday, January 10, 1996**
Time:	**10:00 a.m. to 12:00 noon**
Where:	**Iowa Medical Society Headquarters**
	West Des Moines
Presenter:	**Barbara Cannon, IMS, Director, Medical Economics**
Cost:	**$35.00 for members and staff**
	$45.00 for non-members

Program will feature discussion of NEW 1996 CPT CODES for:

- E&M: Hospital Discharge; Critical Care; Newborn Care
- Application of Casts and Strappings
- Delivery After Previous C-section Delivery
- Pathology/Laboratory
- Spine Procedures
- Wound Exploration
- Immunizations

PPR—Year Five will provide conversion factors for the end of the 5-year transition period and fundamental information affecting 1996 Medicare Fee Schedules. Payment Policy Changes including the -GB Modifier, X-rays and EKGs in the ER, and Mammography Coverage will be reviewed. Discussion will also cover the Correct Coding Initiative (AdminiStar), Focused Medical Review (Post-Payment) activities and E&M Documentation Guidelines.

Using HCFA's E&M Documentation Guidelines & Audit Score Sheets

For physicians and key staff

Wed., Jan 10, 1996*	**Davenport**	**Genesis East Campus Conf. Rm.**
Mon., Jan. 22, 1996	**Cedar Rapids**	**Mercy Hospital, Marron Room**
Tues., Jan. 23, 1996	**Des Moines**	**Mercy Education Center**
Wed., Jan. 24, 1996	**Omaha**	**Methodist Hosp, Cancer Center**
Thurs., Jan. 25, 1996	**Sioux City**	**Convention Center**

Time:	**5:30 p.m. to 8:00 p.m. (light refreshments included)**
	6:00 p.m. to 8:30 p.m. (Davenport only)*
Presented by:	**Barbara Cannon, IMS, Director, Medical Economics**
	Mike Reiling, Sr. Associate, Partners Consulting Group, Ltd.
Cost:	**$49.00 members and staff; $59.00 non-members**

The presentation will be a combined didactic and hands-on workshop focused on the HCFA E&M code documentation guidelines (including a brief review of E&M code selection) and the HCFA audit/score sheet. Please bring a copy of a chart and a copy of the related charge ticket/encounter form for an office visit to use during the workshop.

Registration Form

Name(s): _____

Clinic/Practice Name: _____

1996 CPT Update & PPR—Year Five _____ Using HCFA's E&M Documentation Guidelines _____

Date/Location _____

Address: _____

Phone: _____ Fax: _____

Amount Enclosed: _____ (Please make checks payable to IMS Services.)

Mail check and form to: IMS Services, ATTN: Sherry Johnson, 1001 Grand Avenue, West Des Moines, IA 50265-3599

I M G M A

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Iowa Medical Group Management Association
1001 Grand Avenue • West Des Moines, IA 50265
800/747-3070 • 515/223-1401

IMGMA is an affiliate of the Medical Group Management Association

Newsmakers

AT A GLANCE

Dr. David Paulus, Red Oak family physician, was honored as the Iowa Family Doctor of the Year for 1995 at the Iowa Academy of Famly Physicians' 47th Annual Meeting and Scientific Assembly November 8-11 in Des Moines. Dr. John Ely, associate professor at the UI College of Medicine, was honored as the Family Practice Educator of the Year.

Dr. Dean Gesme, Jr., Cedar Rapids oncologist, has received the St. George Medal of the National American Cancer Society in recognition of distinguished service. Dr. A. Curtis Hass, Cedar Rapids radiation oncologist and medical director of the Mercy Cancer Center, received the Quality of Life Service Award, recognizing his outstanding service and commitment to cancer patients. Both awards were presented October 13 at the American Cancer Society, Iowa Division's annual meeting in Des Moines.

MSAs ease health care squeeze

Letter to the Editor

Dear Editor:

If there was one thing Americans concluded during the 1994 health care debate, it was that price controls and top-heavy bureaucracy are not the answer. Health maintenance organizations (HMOs) are providing doctors and patients just that—price controls and bureaucrats dictating medical treatment procedure.

In addition, expanded use of HMOs does not get at the underlying problem facing our nation's health care system—the exploding costs which threaten the availability of quality health care for many Americans.

Instead, health care providers are forced to shift costs where they can; savings in one area result in added costs somewhere else. The Congressional Budget Office (CBO) states, ". . . it cannot be assumed that further growth of managed care would reduce either the level or the rate of increase of system-wide health spending."

As HMOs expand, there will be fewer areas left to bear the cost shifts. Providers will have to accept less income for their services and/or cease providing charity services and taking Medicare patients, whom doctors already treat at about 70% of cost (according to the CBO).

As for those patients covered under HMOs, the quality of their health care will be threatened. The only way in which insurers and providers can slow rising costs will be to limit the availability of services.

Which brings us to the opportunities presented by medical savings accounts (MSAs). Basically an MSA is a high deductible catastrophic insurance plan accompanied by a savings account which the individual can use for day-to-day health care expenses. Employers and employees deposit their respective shares into the MSA and unused funds in the account collect interest and can be carried into subsequent years. The individual would have an incentive to use the savings account wisely, as any money over a certain balance could be withdrawn for personal use or rolled over into an IRA.

Some have argued that poor people will not be able to take advantage of MSAs. But, U.S. Congressman, Dr. Greg Ganske, writes, "This argument would only be true if the funds in an MSA account were available for non-medical uses . . . MSA withdrawals, however, are only permitted to pay for health care expenses."

Nor do MSAs result in favorable selection or "cherry picking" that has occurred with HMOs. The catastrophic insurance will provide 100% coverage to those individuals whose health costs exceed the deductible.

Although employers are offering MSAs to their employees, inequitable tax treatment by Congress is retarding their growth. Congress needs to act quickly to eliminate this inequitable tax treatment. Also, MSAs need to be offered to Medicare recipients as an option, both for the recipients' benefit and to help maintain Medicare's solvency.

Health care providers, particularly doctors, have been caught in the vice between rising demands and costs for health care and shrinking reimbursements from third-party payers. Medical savings accounts would loosen this grip, allowing doctors and patients to breathe easier.—*Steve Grubbs, state representative, Davenport.*

New members

Ankeny
David Harrison, MD, family practice

Cedar Rapids
Wayne Alberts, MD, family practice
Judith Bernhard, MD, pediatrics
Kin-Kwan Cheuk, MD, internal medicine
Denise Clark, MD, pediatrics
Jerome Janda, DO, family practice

Wieslaw Machnowski, MD, pediatrics
Praful Patel, MD, internal medicine
William Renk, MD, pediatrics
Daniel Trautman, MD, internal medicine
Daniel Vanden Bosch, MD, family practice
George Walker, MD, emergency medicine

Chariton
Timothy Rice, DO, family practice

Charles City
Donald Hall, DO, family practice

Clarion
Richard Unger, DO, general surgery

Cherokee
Howard Fishkoff, DO, resident

Clinton
Ricky Maddox, MD, general surgery

Council Bluffs
Bryan Imamura, MD, radiation oncology

Creston
Neal Brockbank, DO, obstetrics/gynecology

Davenport
Brian Burnett, MD, resident
Jeffrey Carruthers, MD, resident
Christopher Cunningham, MD, vascular surgery
Douglas Dvorak, MD, otolaryngology
Bradley Fox, MD, resident
Paul Glowacki, MD, resident
Clyde Grady, MD, resident
Michael Miller, MD, resident
Alfred Paul, MD, ophthalmology
David Rohlf, MD, urology
Edward Sandy, II, MD, obstetrics/gynecology
Stephen Sorenson, MD, resident

Des Moines
Saramma Alexander, MD, oncology/hematology
Mark Bissing, DO, internal medicine/cardiovascular medicine
Kristi Blomberg, MD, family practice
William Brosnahan, MD, anesthesiology
Joseph Doro, DO, neurology
Joannie Franklin, MD, family practice
Jane Hendricks, DO, internal medicine
Bruce Hughes, MD, neurology
Sayeed Hussian, MD, pediatrics



Stormy Johnson, MD, AMA president-elect, was a guest at a June AMA annual meeting reception held by Dr. Greg Ganske, U.S. Congressman from Iowa. Discussion centered on health care issues coming up in Congress and Medicare.

Bruce James, MD, anesthesiology
Gayla Kees, DO, general practice
Charles King, II, MD, internal medicine/rheumatology
Alan Koslow, MD, general surgery
Amy Kumagai, DO, plastic surgery
Robert Muellerleile, MD, internal medicine/cardiology
Mark Nelsen, MD, cardiothoracic surgery
Leonard Richards, DO, psychiatry
Bradley Riley, MD, pediatrics
Jennifer Robinson, MD, internal medicine
Shoab Ali Sayheed, DO, pediatrics
Kary Schulte, MD, orthopaedic surgery
Hala Shamsuddin, MD, internal medicine/infectious diseases
Ronald Solberg, DO, psychiatry
Mark Souza, MD, psychiatry
Scott Sutherland, DO, family practice

Dubuque
Scott Aigner, MD, urology
Timothy Bowers, MD, emergency medicine
Mark Janes, MD, pulmonology diseases
Ian Koontz, MD, internal medicine
Lloyd Luke, MD, general practice/occupational health
Timothy Martin, MD, internal medicine/cardiovascular diseases

Deceased members

Atlee Hendricks, MD, 84, life member, internal medicine, Davenport, died October 22

Paul Kersten, MD, 76, life member, psychiatry, Nokomis, Florida, died July 10 IM

Last chance!
All Emeritus and Life Members who wish to continue receiving *Iowa Medicine* should call IMS headquarters by January 22. Thanks to those who have already called or mailed in their response.

Elder abuse



Though we live in a violent society, hurting the elderly and children — those who are most defenseless — seems especially deplorable. This month's Iowa Medicine *examines the problem of elder abuse. The following articles by Iowa physicians discuss how to recognize it and what to do about it.*

No culture has been without elder abuse and neglect; however, only since the mid-1970s has it gained the attention of the medical community. In 1975, A.A. Baker described "granny battering". His work generated a plethora of terms noted for their lack of clarity in defining this type of behavior. My own preference is simply "inadequate elder treatment".

Physicians required to report elder abuse

Those of us in the healing arts must report abuse of anyone who is dependent on another for daily needs. We may be charged with a misdemeanor if we fail in this duty.

The prevalence of elder abuse and neglect is estimated at 4% of those over age 65; the actual prevalence may be between 10-15%. In Iowa, there are 426,106 persons over the age of 65. Four percent would mean 17,044 abused elders. At 10%, the best guess would mean we probably have at least 42,610 abused elders.

The reasons for under-reporting are lack of screening, the fear that reporting will make a bad situation worse and ageism. Some health care workers may feel that the elderly person is not worth as much as a younger person and may not live much longer anyway. Our culture's emphasis on youth and beauty doesn't work to the advantage of the elderly.

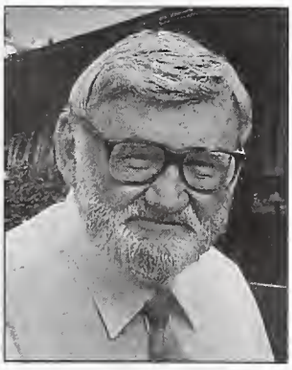
Most abuse done by family members

Abuse can be physical, emotional, psychological, sexual and financial or can be simply neglecting to provide the necessities of life. We tend to view abuse and neglect differently in cases where the care givers are actually trying their best to help the victim but may be doing the wrong thing due to ignorance or stress. Physicians contribute to this problem whenever we treat older adults with less respect than younger patients or speak to and listen to the care giver instead of the patient.

They may be embarrassed for anyone to know their spouse or child is abusing them.

It appears that most abuse and neglect are committed by family members (65% by spouses; 23% by children). The majority of victims of elderly abuse appear to be males because males are less likely to be living alone as they age.

Why does anyone allow abuse and neglect to occur? The victims



STAN HAUGLAND, MD
Dr. Haugland is a family physician who practices at Iowa Methodist Medical Center. He is medical director at the Powell Chemical Dependency Center and chair of the IMS Subcommittee on Aging.

are usually frail, have multiple impairments, are afraid they will end in a nursing home if they tell anyone and sometimes believe they deserve the abuse. They may also be embarrassed for anyone to know their spouse or child is abusing them because this means they have failed as a parent or spouse.

Why do care givers abuse?

Transgenerational abuse and neglect does occur, although much less frequently than other types. In transgenerational abuse, the care giver was abused by the patient over the years and now the tables have turned. Abuse by caregivers with a serious mental health problem also occurs, but these cases are a minority.

Why do care givers abuse? Many are older and becoming frail themselves. Others are simply overburdened with care giving duties in addition to taking care of themselves and their families. Stress is a major factor behind abuse and neglect. This is important for physicians to appreciate because relieving care giver stress may help alleviate abuse.

Whenever abuse is suspected, it is imperative to interview the patient and care giver separately. It may well be that the physician will need to concentrate on the patient while another staff member speaks with the care giver.

Interview in a positive fashion. For the care giver, it is important that questions be asked in a way that indicates you are aware of the burden they may be carrying and that you wish to help, perhaps by sending a social worker or nurse into their home. Having a third party come to the home is often a significant factor in reducing abuse.

What to ask patients, care givers

Questions to ask the care giver include: "How are you getting along?" "How may I help you?" "Does the stress sometimes overwhelm you?" or "How do you reduce your stress?"

Questions to ask the patient include: "Do you feel safe in your neighborhood?" "Do you feel safe in your home?" "Does anyone ever hurt or take advantage of you?" Emphasizing the nature of the physician-patient relationship may encourage the victim to be candid.

In some instances, it may be necessary to recommend that the patient be transferred to an intermediate care facility or into the hospital if circumstances justify an admission. It is important to remember that the physician may be the only individual who sees the victim and the care giver. This means the physician is in a unique position to ameliorate this problem.

Violence against anyone is despicable. It is unlikely that such behavior can ever be eliminated, but it can be ameliorated if we take an interest. We in the helping and healing arts need to remind ourselves that our patients look to us for leadership.

We do not have to like each other, but we need to be kind to each other. Dr. Peabody's address to the American Medical Association in 1927 still holds true. "The best patient care is caring for the patient." IM

The physician may be the only person who sees the victim and the care giver.

SIGNS OF ELDER ABUSE AND NEGLECT

- **Unexplained injuries/accidents**
- **Conflicting stories from the patient and caregiver**
- **Drug/alcohol use by the patient or caregiver**
- **Dementia, tendency to wander**
- **Incontinence**
- **Fear or depression**
- **Dehydration, malnutrition, poor hygiene**
- **Inappropriate or soiled clothing**
- **Caregiver answers all questions, even when questions addressed to the patient**

Elder abuse reporting and ethical dilemmas



In cases of suspected elder abuse, the first consideration is the safety and well-being of the patient. The second priority is to report any suspicion of abuse to the designated state authority.[1]

Physicians are mandatory reporters as are all health care practitioners who in the course of their employment examine, attend, counsel or treat a dependent adult who they reasonably believe has been abused. Any one of these professionals who believes that abuse has occurred but who found out about it outside their job is a permissive reporter.[2]

Iowa has elder abuse hotline

Many states, including Iowa, have an elder abuse hotline for receiving confidential reports about abuse in the community or health care facility. The toll-free 24-hour Iowa number is 800/362-2178 (in-state only).

The person in charge of the dependent adult must be informed of the report and, if there is immediate danger, the local law enforcement agency must be notified. A member of the staff of a hospital or similar institution who attends a suspected victim, must notify the person in charge of the institution. They, in turn, will make the report to the Department of Inspections and Appeals.[2]

Physicians may hesitate to report because to do so would be to breach the confidentiality of the doctor-patient relationship. American Medical Association guidelines for elder abuse and neglect say that a physician's duty to report supersedes the issues of doctor-patient confidentiality. There is little case law on the subject to help physicians make ethical decisions.[1]

Physicians may also be uncomfortable when they report suspected abuse because the privacy of the patient and family is being violated. Another issue is whether the abuse investigation itself might cause harm by disturbing family relationships or by provoking the alleged perpetrator to anger. A dependent elderly person who becomes angry with the physician may be discouraged from seeking future medical help.[3]

Taking the time to talk to the patient and the family is important. It is necessary to explain carefully that physicians are compelled to report by law and that states have the power to protect people who are unwilling or unable to protect themselves.

The goal of reporting is to stop the abuse, to organize help and meet unmet needs. However a 1986 survey of Iowa providers showed that 36% of their clients refused to allow the abuse to be reported.[3]

There is little case law on the subject to help physicians make ethical decisions.

Immunity for good faith reports

A mandatory reporter who does not report dependent adult abuse is guilty of a simple misdemeanor but is also civilly liable for any proximate damages. A person who reports in good faith or assists in evaluating a



Glenys Williams, MD
Dr. Williams is with the University of Iowa Department of Family Practice.

case of abuse is immune from civil or criminal liability.

Before reporting, three facts must be established:

1 That the elder is a dependent adult.

Under Iowa Code 441-176.1 (235B), dependent adult is defined as *a person 18 years of age or older who is unable to protect the person's own interests or unable to adequately perform or obtain services necessary to meet essential human needs, as a result of a physical or mental condition which requires assistance from another.*

2 That the caretaker is identified.

Under Iowa Code 441-176.1 (235B), a caretaker is *a related or unrelated person who has the responsibility for the protection, care or custody of a dependent adult as a result of assuming the responsibility voluntarily, by contract, through employment, or by order of the court.*

3 That lawful abuse has occurred.

(See table below for the Iowa Code definitions of dependent adult abuse.)

Specific time deadlines are established for reporting and investigating cases in Iowa, after the initial call to the Elder Abuse Hotline. (See next page.) Sometimes a reporter is allowed to give the complete report by telephone, otherwise a written report must be delivered to the local, district or state Department of Human Services office, county attorney or a law enforcement agency. The official reporting form may be used or a form developed by the reporter.

Specific time deadlines are established for reporting and investigating cases in Iowa.

The report should contain details of the victim's dependence, the nature and extent of the abuse and the names and addresses of

continued

IOWA CODE DEFINITIONS RELATED TO ADULT ABUSE

Adult abuse means any of the following as a result of the willful or negligent acts or omissions of a caretaker:

1. Physical injury to or unreasonable confinement or unreasonable punishment of a dependent adult.

2. The commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2 with or against a dependent adult.

3. Exploitation of a dependent adult which means the act or process of taking unfair advantage of a dependent adult or the misuse of the adult's physical or financial resources for one's own personal or pecuniary profit by the use of undue influence, harassment, duress, deception, false representation or false pretense.

4. The deprivation of the minimum food, shelter, clothing, supervision, physical and mental health care and other care necessary to maintain a dependent adult's life or health.

5. The deprivation of the minimum food, shelter, clothing, supervision, physical and mental health care and other care necessary to maintain a dependent adult's life or health as a result of the acts or omissions of the dependent adult.

continued

TIMELINE OF DEPENDENT ADULT ABUSE REPORT AND INVESTIGATION

Zero	**Reporter calls Elder Abuse Hotline, 800/362-2178**
1 Hour	**DHS* contacts dependent adult if danger suspected**
24 Hours	**DHS contacts dependent adult if no danger**
48 Hours	**Reporter submits written report to DHS**
96 Hours	**DHS preliminary investigation completed**
10 working days	**DHS report completed**

***Department of Human Services**

the people involved.

It is important to maintain accurate, detailed medical records with notes of conversations and photographs or X-rays, if indicated. All these may be needed in court proceedings and must be stored in a secure area.

May need court-appointed conservator

A complete investigation is then conducted. Investigators may include county attorneys, law enforcement officers, multidisciplinary teams and social service agencies, with the assistance of the physician reporter.

Nobody can force competent elderly people to accept assistance they do not want.

The outcome will be a determination whether the abuse report is founded, unfounded or undetermined. Approximately 25% of the 300 elder abuse cases reported each year in Iowa are founded.[3]

Copies of the completed report are sent to the county attorney, Central Registry, the dependent adult (or guardian) and the alleged perpetrator.

The court may appoint a guardian or conservator and order services, or it may suggest voluntary services such as day care, home health aide or visiting nurses. An incompetent adult who refuses services may need a court-appointed conservator or guardian. In this case, the physician will need to evaluate the patient's cognitive state.

Nobody can force competent elderly people to accept assistance they do not want. Thus, if they refuse the recommended services nothing will have changed. When this happens, the involved professionals are usually very frustrated and may feel that the report, the investigation and the associated stress made no difference to the patient.

Training requirements for reporters

All mandatory reporters must meet state requirements for training on dependent adult abuse. The Code of Iowa requires two hours training within one month of employment (or within six months if group-trained), followed by two hours retraining every five years thereafter. The prescribed curriculum includes recognition of elder abuse and reporting procedures.

Proposed changes in the Iowa elder abuse laws will not alter the reporting laws and are unlikely to affect physicians' roles. Definitions of dependency and caretakers are likely to become more inclusive and some changes are to be expected in how abuse investigations are conducted.

In the long run, increasing public awareness of elder abuse is likely to be more effective in decreasing the incidence of abuse than any changes in the law.

References

References noted in this article are available from the author or the editors of *Iowa Medicine*. IM

Elder abuse — intentional or unintentional?

Abuse and neglect can be categorized as active or passive. Physical abuse may be intentional or unintentional. It is difficult without a social history to differentiate between intentional vs. unintentional abuse and active vs. passive neglect.

Indicators of intentional neglect

Upon evaluation of a patient, there may be certain indicators that there has been intentional neglect. These indicators may include injuries that have not been taken care of properly or have not been reported to the physician.

Apparent fear or flinching as you move toward the patient, chronic cuts, lacerations, puncture wounds and bruises are indicators of abuse. The patient may have both new and old bruises.

Other indicators are: chronic malnutrition, dehydration, pallor and other signs of inadequate care such as bedsores, insect bites, inadequate administration of medication, poor skin hygiene, soiled bed and clothing and burns which have the appearance of cigarette burns.

Unsual signs of fractures, recurring fractures, spiral fractures of the femur and chronic dislocations of the larger extremities may point to physical violence on an intentional basis.

Confining someone, tying them to furniture or locking them in a room are all symptoms of an abusive situation. Bone injuries that have not been seen in a timely fashion are signs of physical abuse. Also be on the lookout for repetitive skin and body injuries.

During home visits, it may be noted that the patient is not dressed appropriately and that the patient needs a walker, cane, etc. but none is available. The house may be cold and the patient may be living in unsafe conditions. This usually is a type of passive abuse, but can be active abuse. Frequent use of an emergency room and doctor shopping may also indicate physical abuse.

During the examination, the physician should carefully evaluate the circumstances of an injury, the type of injury and discuss the nature of the injury with the patient. If you have an established rapport with the patient, you may be able to ask directly if the injury is the result of abuse.

Take note of whether the patient seems fearful of the caretaker or if the patient seems to have a panic disorder.



Facts about elder abuse in Iowa

- Elder abuse is one of the most under recognized and under reported social problems in America. It is far less likely to be reported than child abuse because of lack of public awareness.
- Experts say only one of 14 incidents of elder abuse comes to the attention of law enforcement or human services agencies. Last year in Iowa, 1,000 cases of elder abuse were reported.
- Elder abuse can happen anywhere — in private homes, at health care facilities and in the community. IM



Roy Overton, II, MD
Dr. Overton is a Des Moines family physician specializing in geriatrics. He is also president of the American Medical Directors Association, Iowa Chapter.

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Community resources



DEANNA CLINGAN-FISCHER, JD
Ms. Clingan-Fischer is legal services developer for the Iowa Department of Elder Affairs. Among her other duties, she works with the Department's elder abuse prevention program.

Elder abuse is one of the latest forms of societal violence to elicit concern and is of special concern here in Iowa. Iowa ranks first in the nation in the percentage of persons age 85 and older, second in the nation in percentage of persons age 75 and older and third in the nation in percentage of persons age 65 and older.

It is predicted that elder abuse will be a growing problem in the next century as the population of those over age 60 increases from the current 41 million to 72 million by the year 2000.

Elder abuse can take the form of verbal abuse, sexual abuse, physical abuse, financial exploitation, neglect by the caregiver or self-neglect. Abuse through neglect (failing to provide for the person's basic needs) is more prevalent among older persons and persons with disabilities.

What is available for the victim of elder abuse? A variety of community resources are available to assist victims, families and the public in addressing this issue. IM

ELDER ABUSE — RESOURCES FOR VICTIMS, FAMILIES, PHYSICIANS AND THE PUBLIC

INVESTIGATION

To report suspected abuse in the community: 800/362-2178 (Department of Human Services)

To report suspected abuse in a licensed health care facility: 515/281-4115 or 800/362-2178 (Department of Inspections and Appeals or Department of Human Services)

Suspected abuse reporting/services for long-term care facility residents: 800/532-3213 (Long Term Care Ombudsman)

SUPPORTIVE AND IN-HOME SERVICES

To locate the closest Area Agency on Aging: 515/281-5187 Services available, depending on area, include daily meals, case management, adult day care or respite, assisted housing, home care, personal care assistance, transportation, chore services and needs assessments. Information on Medicaid eligibility and assistance with bill-paying, and representative payee and insurance counseling are also available. Assistance is contingent upon the acceptance of services.

To receive general information or resource materials on abuse: 515/281-4657 (Department of Elder Affairs)

OTHER INTERVENTIONS

Assistance/information to protect abuse victims: 800/532-1275 (Legal Services Corp. of Iowa)

Assistance/information to protect domestic abuse victims: 800/942-0333 (Iowa Domestic Abuse Projects)

To report exploitation of social security or supplemental security income benefit: 800/772-1213 (Social Security Admin.)

To report exploitation of a veterans benefit or to inquire about services: 800/827-1000 (Veterans Affairs)

To report exploitation of railroad retirement benefit or to inquire about services: 515/284-4344 (Railroad Retirement Board)

To report a consumer complaint about fraudulent telephone or mail prize solicitation: 515/281-5926 (Attorney General)

Concerns about the system

The Iowa ElderCare Coalition Subcommittee on Elder Abuse has identified the following concerns and problems with the system set up to deal with dependent adult abuse.



PROBLEMS IN THE SYSTEM

- Guardians or conservators are not always available for low-income clients.
- Even clients with income cannot always find an appropriate guardian or conservator.
- Services cannot be initiated in "founded" cases unless the client and/or care giver agree to receive the services or a guardian is appointed who consents to services for the client.
- Accessible emergency services such as emergency respite care or emergency protective services for adults are not available.
- There is a lack of alternative places to live such as foster homes or other non-institutional living arrangements. Many choose to stay in an abusive situation rather than face the unknown.
- Mandatory reporting of suspected abuse can jeopardize the relationship of trust betwen the client (victim) and those attempting to help such as the physician or the agency providing services.
- There is a lack of public awareness about the extent and causes of elder abuse.
- There are inadequate resources allocated for prevention, enforcement of the statute and provision of services.
- Background checks of professional care givers are not always conducted.
- Evaluators do not specialize in adult abuse and need more training in working with elderly victims.
- There is a lack of coordination between agencies involved in dependent adult abuse issues.

PROBLEMS WITH THE LAW

- The definition of what "dependent" means is unclear as it relates to dependent adults.
- The law narrows the potential perpetrator to the care giver, disregarding others who might be involved.
- There is confusion over the concepts of child abuse, domestic abuse and dependent adult and elder abuse.
- The victim must initiate legal action by filing charges.
- Psychological or emotional abuse is not specifically addressed in the law.
- Consequences are not incorporated into the statute.
- The mandatory reporters definition should include employees of financial institutions.

PROPOSED CHANGES

In response to concerns identified by the Elder Abuse Committee, Area Agencies on Aging and service providers, the Department of Elder Affairs plans to introduce draft legislation which would change portions of the current dependent adult abuse law.

The proposed changes to the law redefine the terms "caretaker", "dependent adult" and "exploitation" and proposes creation of a multidisciplinary team to assist in assessing the needs of dependent adults who are victims of abuse, neglect or exploitation.

The proposal would also add a new section to the law to allow legal remedies for the victim. IM

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of the Iowa Medical Society

Diagnosing and managing elder abuse

● GERALD JOGERST, MD

Over the last 25 years, the image of domestic tranquility has been challenged by the reality of abuse. The home can no longer be seen as immune to the violence that affects other aspects of American life and the elderly must be added to the list of those affected by violence. This article discusses the prevalence, characteristics, assessment and potential interventions for elder abuse.

Elder abuse defined

A general definition of elder abuse is acts of commission (abuse) or omission (neglect) that result in harm or threatened harm to the health or welfare of an older adult. The term elder mistreatment is used to define physical, psychological and financial abuse or neglect. This mistreatment can be further divided into intentional or unintentional harm. Intentional is the conscious or deliberate intent to inflict harm or injury such as battering; unintentional is the inadvertent act resulting in harm caused by ignorance, inexperience, or lack of ability or desire on the part of a care giver. Unintentional mistreatment would also apply to the individual who is self-neglecting because of cognitive or other deficits.

It is estimated that between 2% and 5% of the elderly are being mistreated. Using random sample surveys, Pillemer and Finkelhor demonstrated that 32 of 1,000 older adults were mistreated at least once since reaching age 65 and that there was an annual incidence rate of 26 out of 1,000 elderly population.[1] It is further estimated that only 1 in 14 mistreatment cases is reported to public agencies.[2]

From January of 1983 through December of 1992, 1.7% of Iowans 65 and older were reported to the Department of Human Services as potential abuse victims. In rural counties, the 10-year prevalence report rate was approximately 1%. If only 1 in 14 cases is reported, Iowa's yearly prevalence rate of mistreatment is 2.4% in non-rural and 1.4% in rural counties.

There are many theories on the etiology of elder mistreatment, most of them unsubstantiated with good clinical data. Theories include transgenerational violence where the child who is abused grows up to be a spouse abuser, then graduates to be abused as an elder. Psychopathology in the caregiver who suffers from alcohol and drug addiction or emotional problems is another potential source for abuse.[3] Dependency and vulnerability of the victim and stress from economic pressures, lack of community support and increased care needs are also cited as potential causes of abuse.[4,5]

Since the mistreated elderly may be isolated, the physician caring for this person must screen for potential abuse. Examples of screening questions would be, "Has anyone at home ever hurt you?" "Has anyone taken anything that was yours without asking?" "Are you afraid of anyone at home?" It is important to examine the elderly patient away from the caregiver. Asking screening questions on a regular basis may yield positive answers as rapport is established with the patient.

To diagnose and document clinical findings of elder mistreatment requires a comprehensive medical examination with documentation of the patient's statements, behaviors and appearance.[6] If possible, obtain photographs of visible physical findings. Types of mistreatment include physical abuse (pushing or striking) and sexual assault. As with child abuse, unexplainable physical injuries

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for January 1996.

GERALD JOGERST, MD
Dr. Jogerst practices with the University of Iowa Department of Family Practice.

Diagnosing and managing elder abuse

continued

must raise suspicion. Physical neglect can include withholding of adequate meals and failure to provide eye glasses or dentures. The patient may present with dehydration or pressure ulcers. Financial or material abuse include stealing and coercing the elder to sign contracts or change wills. Financial neglect may take the form of failure to use available funds to sustain health or substandard care despite adequate finances. The violation of personal rights is another form of abuse which comes with denial of privacy and the right to make desicions. This may also include forcible placement into a nursing home.

Safety is first priority

The patient's safety must be the first consideration.[7] Is the patient in immediate danger? If safety is a concern, the patient needs to be removed from the environment; in some situations, short-term hospitalization or nursing home placement is the only alternative. If the person is returned to the present environment, are there barriers to further assessment? If the patient is unlikely to return, provisions may need to be made for short-term placement in a controlled environment.

The following case is presented to illustrate the importance of early detection of abuse to prevent subsequent injury.

Louise D. is a 68-year-old who was seen in the office of her local physician starting in November of 1988. The patient had been living in a board and care facility. On November 21, 1988, the office note indicated "uses a walker, primarily due to residual right-sided hemiparesis." In June of 1989, there was a no-show appointment; the patient was seen in February of 1990 for a sore of the right leg that wouldn't heal. The patient was followed up in April of 1990 at which time she had a blood pressure of 182/120 in her left arm. The patient did not show up for two appointments scheduled in May of 1990 but came back to the office in June of 1990 in a wheelchair. There was a 5 cm irregular, deep, somewhat necrotic ulcer on the back of the calf as well as the heel of the left lower leg. A shallow left anterior leg ulcer was present. The plan was to use Elase with Chloromycetin ointment and it was recommended the patient return in one month. This was the last visit to the local physician's office. Between July 13, 1990 and December 11, 1990 there were eight calls to the physician's office for refills of medication, four for the Elase with Chloromycetin ointment.

The patient was dependent upon the care giver at the board and care facility to come to the office and, over a one-year period, there were three missed appointments and a delay in return for appointments for serious medical problems. There was no follow-up after June 20, 1990 for serious pressure ulcers. A pattern of neglect was shown by the caregiver as well as failure of the physician to recognize a neglectful or abusive situation.

On December 12, 1990 the patient was seen in the hospital emergency room. The record documents, "foul smell from wounds of buttocks x 3, and left foot, left heel ulcer, to calcaneus." The patient was admitted to the hospital with a diagnosis of decubitus ulcers, multiple and severe; gangrene, diabetes, desseminated candidiasis, streptococcal septicemia, chronic osteomyelitis left leg, adult maltreatment syndrome, late effects of cerebral vascular disease (left hemiparesis), aphasia and hypertension. The patient underwent debridement of the pressure sores as well as skin graft, large bowel exteriorization and below-the-knee amputation on the left. Pressure ulcers were described as right ischial with exposure of underlying isehial tuberosity externally measuring 10 x 12 cm with subcutaneous tunneling to a second ulcer on the sacrum measuring 18 x 20 cm to the sacral preligamentous structures. There was a left trochanteric 10 x 12 cm pressure ulcer down to the trochanteric prominence. Left ischial ulcer measured 8 cm x 7 cm with no exposure of underlying ischial tuberosity.

Cultures were obtained and the patient started on Timentin and Flagyl. Social services and adult protective service referrals were made and surgical consultation was obtained. The patient's albumin was 1.6 with a cholesterol of 67, signifying severe malnutrition. A chest x-ray noted bilateral healed rib fracture deformities and an old healed severe fracture deformity of the right humeral neck.

There is overwhelming evidence of a pattern of conduct which resulted in deprivation of services necessary to maintain minimum

physical health in this dependent patient. Negligent behavior before the admission to the hospital eaused injury ineluding massive pressure sores which significantly endangered her life. Serious injuries may have been avoided if the local physician recognized the clues to abuse and neglect. There was a pattern of no-show appointments and the requests for medications to treat pressure ulcers that should have triggered further intervention.

Abuse can occur anywhere

Physicians need to keep in mind that abuse occurs among men and women of all racial, ethnic and social economic groups. Perpetrators of abuse are often one's spouse or an adult child. Physical and cognitive impairment, mental illness, alcoholism, and drug abuse in the older person or in the care giver may be associated with mistreatment. Other factors are social isolation and dependenee, past abusive relationships, financial or other family problems, inadequate housing or unsafe conditions in the home. Victims may experience several forms of mistreatment. A physician may be the only contact the abuse victim has outside of the home and it is our duty to be alert for signs of mistreatment.

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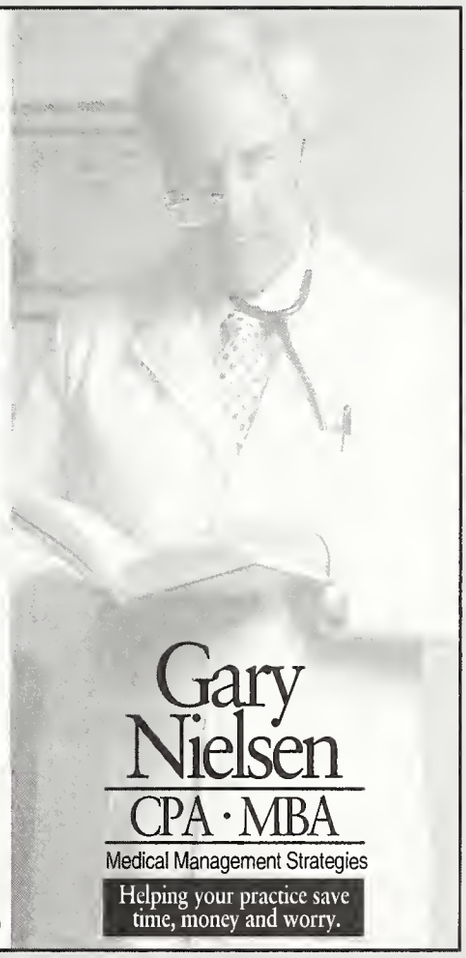
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A New Year prayer: renew family values

The family is one of nature's masterpieces.
George Santayana (1863-1952)
Philosophical writer and essayist

At the start of the new year, let us examine one of our society's most serious problems—violence. In previous issues of *Iowa Medicine* (January and February 1995) we addressed domestic violence in our society. We must face also the prevalence of violent crime perpetrated by some youth of today. Though statistics show that the overall crime rates have dropped slightly in America, teenage crime has been rising steadily.

Patrick F. Fagan, Fitzgerald Fellow for Family and Cultural Studies at the Heritage Foundation in Washington, D.C., declared recently that the real root cause of violent crime is the breakdown of the family.

A study in 1988 of 11,000 individuals found that single parent households with children between the ages of 12 and 20 are associated with higher rates of violent crime and behavior. The same study made it clear that the association of race and crime is false. The absence of a complete family unit increased crime among whites as well as blacks.

The absence of a complete family unit increased crime among whites as well as blacks.

Increasing percentages of children entering kindergarten have unmarried teenage-mothers. It has been predicted that the rate of illegitimate births will reach 50% in the next 12-20 years. A lack of family cohesiveness can breed a lack of values which have been the tradition of family life. Conflicts with the parent can lead to violence. Violent families produce violent youth who in turn produce violent communities.

The pattern in the development of the future violent criminal:

Stage 1: Parental neglect and abandonment of the child in early life.

Stage 2: The embryonic gang becomes a place to belong.

Stage 3: The child joins a delinquent gang.

Stage 4: Violent crime and full-fledged criminal gang activity emerge.

Stage 5: A new generation of criminals is born as the youngster abandons the girl whom he has impregnated.

Rebuilding stable families and communities will not be easy, avers Fagen. He outlines four simple principles for affirmative action: 1) marriage is vital; 2) parents must love and nurture their children physically and spiritually; 3) children must be taught how to relate to each other; and 4) the backbone of strong communities is friendship and cooperation among families.

For the sake of our children, our own lives, our communities and our nation, let us resolve for the new year to rebuild the family structure. IM



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Informationally challenged

In a politically correct society that seeks euphemisms such as "vertically challenged" for "short," I refer to myself as "informationally challenged". A problem: is my challenge quantitative ("too much," "too little") or qualitative ("incorrect," "useless")?

Years ago I tried to establish the source of the notion that "medical information has a half-life of five (or seven) years." I centered on J. Robert Oppenheimer, who made that sort of unattributed comment regarding atomic physics. How the metaphor became a frequently repeated shibboleth of medical education I could never learn. I believe it's an unverifiable falsehood, since so much of daily practice uses long-established knowledge and skills.

Of course there are loads of new information, some of it even true. The dilemma is to sift through it for the applicable nuggets. We are deluged with journalistic hype, the current advances in information technology, the entrepreneurial spirit of egotistical and acquisitive folk who labor in the arenas of clinical pharmacology, surgical techniques and even basic scientific laboratories. A simultaneous boon and curse have been laid upon us by such technological pioneers as Johannes Guttenberg, Alexander Graham Bell or Bill Gates. Thoreau said, "I hear a telegraph now permits Maine to speak to Texas, but it may be that Maine has nothing to say to Texas." T.S. Eliot has phrased the challenge this way: "Where is the wisdom we have lost in knowledge?/Where is the knowledge we have lost in information?"

Of course there are loads of new information, some of it even true.

The skills of information retrieval are now a formal part of the U of Iowa's new curriculum for medical freshman. Finding truth and quality in a tidal wave is mighty tough. Socrates tried to teach his students to find truth through reasoning, a technique still exceedingly valuable. To experimentally verify hypotheses by repetition and accurate prediction works just fine to test Newton's equation for acceleration by rolling steel marbles down an inclined plane. But to replicate clinical studies to attain a convincing demonstration, for example, about the efficacy of various treatments for a Stage I prostate cancer in a 70-year-old-man—that's quite a differently colored horse. Even if the statistical story were unassailable, the patient and his doctor must still make decisions that depend greatly on unquantifiable value judgements.



RICHARD CAPLAN, MD

The information revolution is a marvel to behold. But it doesn't answer the ancient philosophical conundrums. Socrates and his intellectual lineage have always urged the search for truth and wisdom, yet Socrates declaimed against writing, fearing it would produce atrophy of memory. We've made it over that hurdle, but (to mix my metaphor) only to enter a different frying pan. IM

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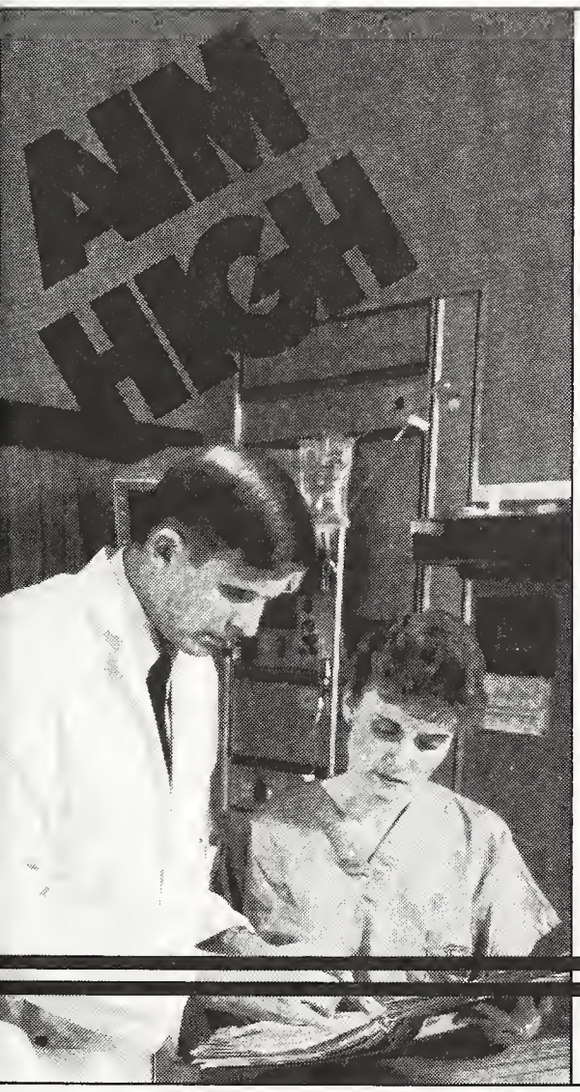
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Iowa Medicine

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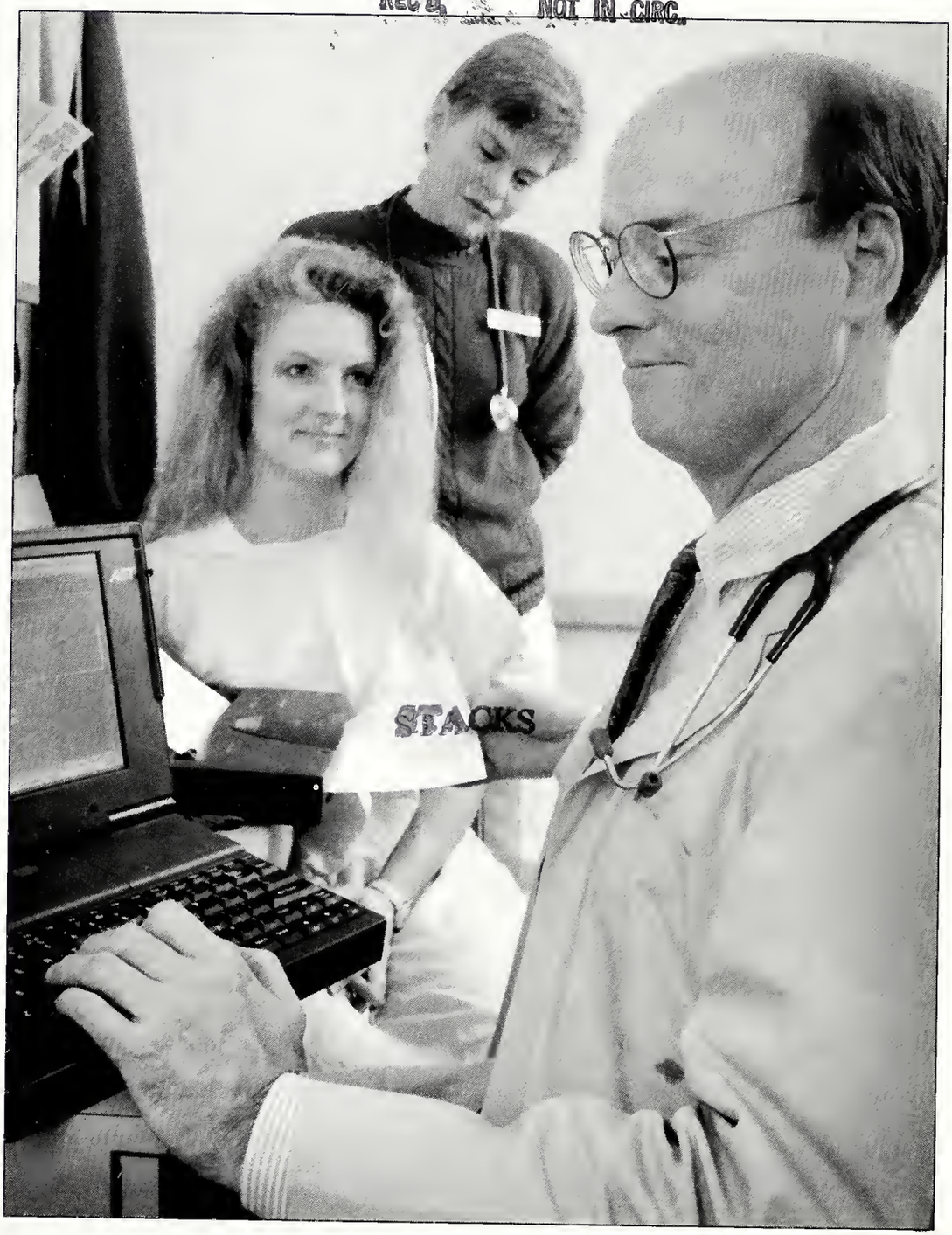
An Iowa experiment: computerized medical records
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An Iowa data study of cesarean rates yields interesting results
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Health management data sets: benefits (and risks) for physicians
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Someone from the world of automation advises Iowa physicians, "Try it, you'll like it."

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Insert:
Computers as a tool in your practice — applications are increasing daily.

Managed care — News you can use
This month's Managed Care News *focuses on why a PO should be the basis for any health care delivery entity.* *See page 53*



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IMS *DEADLINE* news

FEBRUARY, 1996

Late-breaking news of interest to Iowa physicians

●**GEOGRAPHIC PRACTICE COST INDICES (GPCIs)** for Iowa physicians in 1996 have been published by HCFA. They are: Work – .960; Practice Expenses – .877; and Malpractice – .679. (In 1995, the GPCIs were .968, .898 and .672, respectively.)

●**ALSO, HCFA HAS DETERMINED THAT NET DOLLAR INCREASES** caused by changes in RVUs for codes reviewed as part of the 1996 annual refinement process AND addition of new codes for 1996 would add about $140 million to projected expenditures during 1996. Therefore, HCFA will adjust the physician fee schedule conversion factors (CF). All CFs have been adjusted by a uniform adjustment factor of .9964, which results in a uniform reduction of 0.36% to the CFs for all services. This is the first year that the required budget neutrality adjustment has been applied to the CF. AMA has long supported using CFs instead of RVUs for these adjustments.

●**AS EXPECTED, THREE BILLS HAVE BEEN** introduced in the Iowa Legislature regarding the length of a postpartum hospital stay; at press time, at least two more were expected. The bills came in response to policies by several payers to limit insurance coverage of obstetrical stays to one day for normal deliveries. Both the IMS Committee on Legislation and the Board of Trustees have expressed concern over the legislature mandating insurance coverage for specific hospital stays. However, given the political situation in the legislature, the Board has approved a recommendation that the IMS support bills which leave the decision over the length of obstetrical stays to the patient and the physician. The IMS will oppose any bills which allow third party payers to arbitrarily decide when obstetrical patients are to be discharged.

●**THE MERCY – FINLEY DUBUQUE HOSPITAL MERGER WHICH** was challenged by the U.S. Justice Department/Federal Trade Commission but later given the green light in U.S. District Court has drawn the attention of the *Wall Street Journal*. A January 4 article said the case has national implications because the basic issue is whether "one hospital can be better and cheaper than two". The article further speculates that the court ruling in favor of the merger will embolden other hospitals to seek mergers they may have shied away from before. As of press time, the U.S. Justice Department had appealed the ruling and Mercy and Finley hospitals had filed cross appeals.

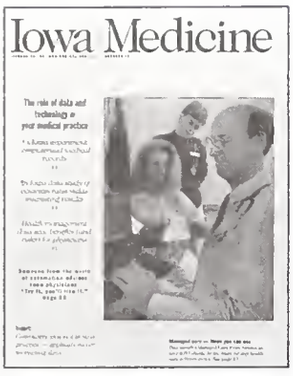
●**A POLK COUNTY DISTRICT JUDGE** ruled last week that the Statement of Charges filed by the Board of Medical Examiners against an Iowa physician is public record but that the information contained in the statement must be limited. The John Doe case involved a physician charged by the BME who attempted to keep his name from being made public. The IMS filed an amicus brief in the case and Judge Gamble's ruling is consistent with the position taken by the IMS – that the Statement of Charges is a public document but that the content of the statement should be "a short and plain statement of the matter asserted". As of press time, it was not known whether the physician would appeal the ruling.

●**AT ITS RECENT MEETING,** the IMS Board of Trustees approved submission of a bylaws amendment regarding specialty society representation in the IMS House of Delegates. The amendment allows a specialty society with a seat in the AMA House of Delegates, whose state chapter has existed for five years and which maintains a 75% level of IMS membership to have one delegate to the IMS House. For more information, contact Dean Gillaspey of the IMS staff.

For more information about any *DEADLINE* news item, call Chris McMahon at IMS headquarters, 515/223-1401 or 800/747-3070.

Iowa Medicine

FEBRUARY 1996 / VOLUME 86 / 2



About the Cover

Dr. William Langley, a Rock Island family physician, was part of a pilot project to test how physicians react to using computerized patient records (CPR). He is pictured on this month's cover using the CPR during an examination.

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EDITORIAL

51 **Point of service and patient choice**

Not everyone understands the difference between Point of Service (mandatory or optional) and Any Willing Provider.
● *THE PRESIDENT COMMENTS*

Do you have a fear of computerized medical records and other forms of office automation? On page 53, someone from outside the medical world says *"Try it, you'll like it."*

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66 **Iowa experiment: computerized patient records**

How do practicing physicians react to a sudden change to computerized medical records? Read this account of a Quad Cities experiment. ● *WILLIAM LANGLEY, MD*

69 **Iowa data study: cesarean sections**

The cesarean section rate in Iowa could be safely reduced, but no one is sure how much. This article discusses a recent study of cesarean section rates in all Iowa hospitals.

Though the future of CHMIS is in doubt, automation in the world of medicine marches on. Don't miss this month's *Iowa Medicine* insert on computers in your medical practice. It contains plenty of useful information on electronic claims submission, billing and computerized medical records.

SCIENCE AND EDUCATION

71 **Health management data sets: benefits (and risks) for physicians**

High quality data which is interpretated appropriately has many potential benefits for physicians, says the author. ● *ROBERT REITER, MD*

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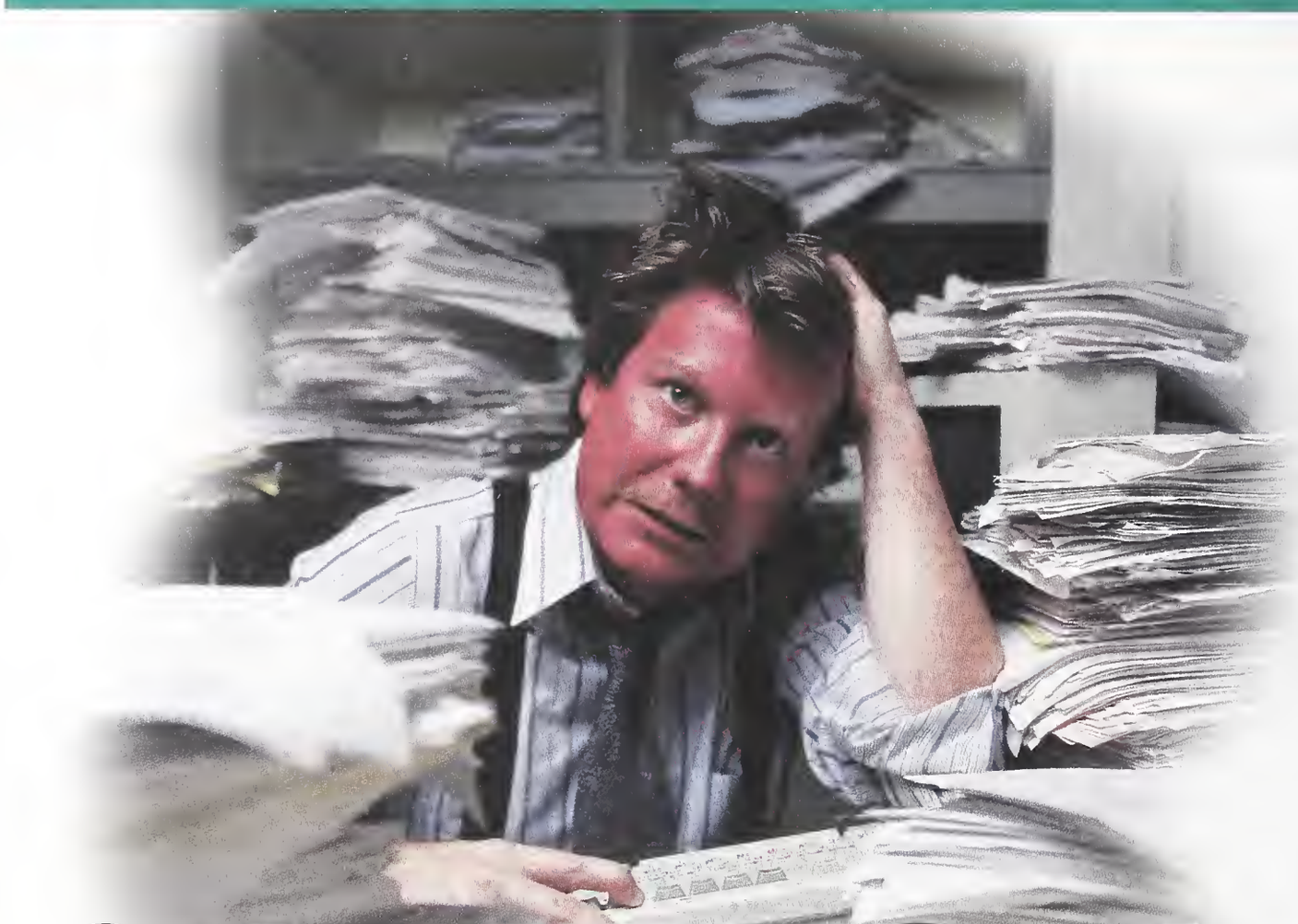
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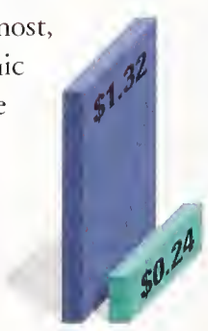
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Point of service and patient choice

Over the past two months my conversations with business leaders and colleagues lead me to believe there is confusion about point of service (POS) and how it differs from any willing provider (AWP). I am sure most patients and employees are also confused, provided they are even aware of the two concepts. POS refers to an option in a health care plan with a restricted panel which allows the patient to seek care outside of the closed panel or network. AWP means any health care provider who agrees to abide by the plan's rules and regulations must be accepted as a provider. These two concepts are clearly different.

The POS feature typically allows an HMO enrollee to seek health care service outside of the providers network at a higher deductible and with a higher co-insurance and out-of-pocket limits.

The POS feature becomes further confused by the issue of whether POS is optional or mandatory. Either optional and mandatory POS can apply to health plans that restrict choice of physicians or hospitals, HMOs or other managed care organizations. Under the optional POS policy, an enrollee is free to join or not join an HMO with a POS feature. If the HMO has no POS feature, the enrollee can purchase an additional POS rider.

Mandatory POS feature means that all managed care plans or closed panel plans must have a POS feature built into the plan. An enrollee in this plan is unable to decline inclusion of the POS feature in an HMO or closed panel and must pay an additional cost that may accompany the "automatic" inclusion of such a feature.

I had the opportunity to serve on a reference committee at the AMA Interim Meeting of December 1995 which heard testimony in regard to the official AMA position. Substantial testimony favored the mandatory POS feature and that it represents the ultimate guarantee of providing patients with the right to select the physician of their choice. Extensive testimony was also heard favoring the current AMA policy (an optional POS feature) because it is consistent with the extensive and long-standing AMA policy on pluralism, is fiscally fair to patients and politically feasible.

He believes mandatory POS features are not politically viable.

During the December break, I spoke with my congressman, Dr. Greg Ganske. He believes mandatory POS features are not politically viable. Dr. Ganske introduced the idea of mandatory POS at the committee level in the House (this was done in spite of the fact that the committee chairman had expressed a desire for him to refrain). The proposal failed on a voice vote at the committee level.

I believe physicians must do all we can to enhance patient choice of physicians and the type of health insurance or health plans that are available to our patients. IM



JOSEPH HALL, MD

MANAGED CARE

news you can use

Fifth hospital joining Des Moines-based Iowa Health System

St. Luke's Regional Medical Center in Sioux City will merge operations with Iowa Health System, pending federal approval expected early this year. St. Luke's will retain local control of its assets. Iowa Health System was created in 1993 with the merger of Iowa Methodist Medical Center and Iowa Lutheran Hospital in Des Moines. During 1995, St. Luke's in Cedar Rapids and Allen Memorial Hospital in Waterloo also entered the system.

Register editorial issues word of caution on managed care

A recent editorial in the *Des Moines Register* cites a recent study of heart-attack survival rates among the elderly which showed that patients fared better when treated by specialists. The study of 220,000 Medicare patients has "obvious implications for managed care", said the *Register*. "The study would seem to indicate that saving money by not referring heart attacks to cardiologists will exact a price in shortened lives", concluded the editorial.

State will ask for contract proposals for prison medical service

Officials with the Department of Corrections say they plan to ask contractors to submit proposals for providing health care services in eight Iowa prisons, replacing state employees with private contract workers. However, the Department's legislative liaison said University Hospitals in Iowa City will continue as a major provider of services to inmates.

MBC representatives barraged with complaints in Dubuque

Representatives of MBC of Iowa, the managed care company administering mental health services for Iowa's Title 19 patients, were barraged by a long list of complaints at a special meeting of the Dubuque County Board of Supervisors. The complaints came from providers, hospital administrators, legislators and others. Access to care and payment for care rendered were the two biggest issues of concern. Representatives of MBC said they are trying to understand what their clients needs are and are working to initiate changes.

Principal will offer HMO products in Waterloo

Principal Health Care will soon begin offering its HMO products in the Waterloo area. The company has offered its PPO to the Waterloo area since 1993 and will offer the HMO products in response to interest from employers in the area. Principal's PPO serves nearly 20,000 employers and dependents in the area.

No managed care Medicaid options in 15 Iowa counties

As of December, 1995, 15 Iowa counties had no managed care options under the Medicaid program. The Department of Human Services currently operates two managed care options in the remaining counties: MediPASS and HMO. There are four HMOs enrolled in the Iowa Medicaid managed health care program.

Step One in forming a new entity? A Physician Organization (PO)



One physician has little strength in the new health system but a group of physicians is an entity to be reckoned with.

'Build from a strong base' has always been sound advice in construction, it is now equally good advice in health care. In our emerging health care delivery system, building from a strong base is the best advice. This means starting any new system with a physician organization (PO).

POs put physicians in control

In the PO, physicians can maintain an independent practice yet benefit from a cooperative arrangement among these practices. A PO is structured so that physicians are in control rather than insurers or other providers.

Once the base is established through the PO, additional building and growth can begin (i.e. contracting with hospitals, other providers and managed care organizations; sharing data systems and purchasing pools).

In 1993, the AMA and three state medical societies conducted a study of POs associated with PHOs. The initial study confirmed the importance of starting with a PO before moving into other systems.

Physician leadership a key requirement

Constructing the delivery entity by starting with a PO enables physicians to build consensus, set goals and establish business plans. When a PO enters into business relationships, things function much better for the physicians. The recently-released follow-up report to the AMA study continues to support the wisdom of starting any new entity with a PO.

The development of a PO can be time-consuming and costly. Well-organized and motivated physician leadership is a key requirement. Start-up capital is another challenge but innovative funding sources such as the AMA's Physieian Capital Source are friendly to newly-developing POs.

The AMA's Capital Source program is designed to help physicians build and lead new delivery networks. It gives physicians access to business, legal, financial and managed care experts who can help them develop business plans. It also links physicians with potential capital sources.

Defense against 'divide and conquer'

Several communities in Iowa have started POs. Each PO is structured a little differently and will function as best serves the physician members. Here are some of the key benefits of starting with a PO:

- Unifies physicians and provides physician leaders;
- Economies of scale and enhanced administrative efficiency;
- Solid defense against 'divide and conquer' activities from outside the physician community;
- Flexibility in structure and operation;
- Physician autonomy preserved;
- Physician owners make decisions.

Constructing the delivery entity by starting with a PO enables physicians to build consensus, set goals and establish a business plan.

MANAGED CARE RESOURCES AVAILABLE FROM IMS

WRITTEN MATERIALS

Establishing a Physician Organization — AMA publication
Access to Capital — AMA publication
Group Practice Options: From Medical Corporations to Clinics Without Walls — AMA publication
Forming Physician Networks — AMA publication
Establishing a Physician Organization — James Dechene
Case Study Analysis of Physician Organizations— Tom Gorey
The Michigan PO to PHO Experience — William Carbone
A Guide to Forming Physician-Directed Managed Care Networks — Texas Medical Association publication
PO/PHO Development — Michigan State Medical Society publication

CASSETTES

Creating Physician Integrated Networks — AMA Doctor's Resource Service
Perspectives on Access to Capital — AMA Doctor's Resource Service

VIDEOTAPES

Forming Integrated Networks: Challenges and Strategies — AMA Doctor's Resource Service

The IMS has a comprehensive lending library of managed care materials including articles, booklets and audio and videotapes. Call Sherry, ext. 629 at IMS headquarters, 515/223-1401 or 800/747-3070, for more information.



Two million dollars in coverage limits!!! Yes, that's the new high protection level insureds now have under the Iowa Medical Society-sponsored STATEWIDE PHYSICIANS HEALTH INSURANCE PROGRAM.

Coverage levels were doubled in 1995 by Blue Cross Blue Shield of Iowa. So, now the 10,000 SPHIP insureds have protection to cover virtually any catastrophic situation.

If you're not one of the SPHIP insureds, you may want to explore the program's many coverage options — both medical and dental. We'll be glad to supply information specific to you and your practice.

Endorsed and overseen by the IMS for its members, their families and employees, the SPHIP has been underwritten by Blue Cross Blue Shield of Iowa since the program began more than 40 years ago. Today's program incorporates various deductibles and coverage formats.

Please call Ruth Clare, Terri DeGroot, Patty DeFrancisco or Skip Lowe for information about the program.

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Computer phobia — fear of automation

Life is ironic. The same health care professionals who understand their patients' fears during the course of treatment can feel the same type of fear when it comes to patient record automation.

The best prescription for health care professionals who fear automation is information.

Most industries spend up to 6% of revenues on data systems; health care devotes barely 1%. As a result, health care remains awash in paper. In fact, the amount of paper utilized in the health care field is growing.

Today's paper-based record weighs about 4 lbs. The explosion of information destined for the patient chart will increase this weight. File space for paper-based records is limited and storage costs are rising.

At times, the paper record is incomplete or illegible. Health care professionals find it difficult to spot trends and perform instant analysis in a paper-based record. In addition, only one person at a time can use a paper record.

An April, 1992 article in the *Wall Street Journal* reported an accurate diagnosis is not recorded in 40% of charts. Tests are reordered in 11% of cases because the original test results are not found in the chart. According to the article, the physician cannot gain access to the patient's medical record during 30% of patient visits.

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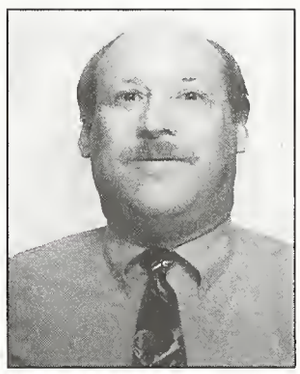
American ingenuity is coming to the rescue as patient record systems emerge in many different formats. This may invoke another fear among health care professionals — fear of choosing the wrong software.

A 1991 study by the Institute of Medicine defined the following requirements for computerized patient records (CPR):

- The CPR should support patient care and improve quality.
- The CPR should enhance productivity and reduce administrative costs.
- The CPR should support clinical and health services research.
- The CPR should accommodate future developments in technology, policy, management and finance.
- The CPR must have a mechanism in place which ensures patient confidentiality.

Computerized patient records should improve documentation. Doctors, nurses and transcriptionists will spend less time creating and maintaining the chart. Authorized access will be available from office, home or hospital.

For the health care professional, patient record automation will increase productivity and improve patient care. IM



Steve Rau

Mr. Rau is vice president of Care Information Systems, Inc., developers of ChartKeeper, a computer-based patient record.

IMS Update

AT A GLANCE

Final IMS/AMA dues notices will be sent to IMS members in mid-February. Prompt payment of dues will be appreciated; dues are considered delinquent on March 1.

In January, IMS officers met with representatives of the IH & HS (formerly the IHA) to discuss issues of mutual concern.

IMS election process continues

Delegates to the 1996 IMS Nominating Committee are being chosen at district caucuses around Iowa. The Nominating Committee will meet by telephone Sunday, March 10. The election will take place Sunday, April 21 during the final IMS House of Delegates session.

Offices to be filled include: president-elect, vice president, trustee, House speaker and vice speaker, three AMA delegate seats and one AMA alternate delegate seat. Also, councilors are up for election in Districts 2, 4, 5, 10, 11 and 14.

Award nominees sought by IMS

The IMS is seeking nominees for its Physician Award for Community Service and the 1996 Outstanding Iowa Medical Office Administrator Award. The awards will be presented at the 1996 House of Delegates. The deadline for nominations is March 1.

Anyone can nominate a physician by writing to Dean Gillaspey at the IMS. The recipient will be chosen by the Board of Trustees.

The Outstanding Iowa Medical Office Administrator Award recipient will be chosen by a committee of Iowa Medical Group Management Association members and will also be presented at the House of Delegates.

To nominate a manager for this award, call Dana Petrowsky at IMS Services, 515/223-2816 or 800/728-5398.

Future IMS House of Delegates meetings

The following dates and locations have been chosen for future meetings of the IMS House of Delegates:

1996 — Fri. - Sun., Apr. 19-21 • Embassy Suites
1997 — Fri. - Sun., April 18-20 • Embassy Suites
1998 — Fri. - Sun., April 17-19 • Marriott
1999 — Fri. - Sun., April 16-18 • Marriott

IMS responds to Federation study

The IMS Board of Trustees has endorsed a report from John Rhodes, Jr., MD, the IMS representative on the consortium which is studying the federation of organized medicine.

Final recommendations from the consortium participating in the study were presented at the AMA Interim Meeting in December. Some recommendations were adopted, key proposals were delayed until the June AMA House. The Board supported the opinion that the only way to gain new membership in the AMA is to provide more representation to specialty societies. The Board also said that all parties involved need to discuss the fiscal ramifications of the study's conclusions.

Specialty Society Update

The Iowa Psychiatric Society Executive Council met in January to discuss managed care issues and a $7,000 grant from the American Psychiatric Association for IPS efforts in managed care. This is the first such grant given to a district branch and recognizes ground-breaking work. The Mental Health Advocacy Coalition is also meeting to discuss legislation which would require parity for mental health services under Iowa insurance plans.

The American Medical Directors Association, Iowa Chapter, will hold its spring meeting May 10 at the Iowa State Center. The conference will focus on team management of the gero/psych long term care residents.

The IMGMA Advisory Committee to the IMS Executive Vice President is scheduled to meet February 12 to discuss legislative issues. The Uniform Credentialing Committee met January 17.

The Iowa Oncology Society Board of Directors will meet February 7 to discuss proposed guidelines for Medicare certification for mixing chemotherapy medicines.

For more information about specialty society activities, call Dana Petrowsky at IMS Services, 800/728-5398.



Cheri Jensen

New IMS staff member

Cheri Jensen has joined the IMS staff as meeting planning coordinator. Cheri will be assisting all other IMS staff members with hotel and meeting arrangements and in planning many special events.

Ms. Jensen held similar positions at Principal International, Commtron and Iowa Methodist.

BME seeks peer reviewers

The Iowa State Board of Medical Examiners is looking for physicians to participate in its peer review committees. All specialties are needed, but especially needed are physicians who are knowledgeable about less common procedures and new or unusual techniques.

Physicians serving on these committees are an important part of the process of ensuring that physicians being investigated or charged by the BME receive a fair hearing and have their cases reviewed by peers.

Any interested physician is urged to call Ann Martino, Ph.D., 515/281-5171.

IMS 'Medicine Day' at Iowa Legislature

Wednesday, March 6 will be 'Medicine Day' at the Iowa Legislature—a day for physicians, spouses and clinic managers to see how the legislative process works. The day will include lunch at IMS headquarters and an afternoon at the statehouse. To register, call Paul Bishop or Lyn Durante, 515/-223-1401 or 800/747-3070 by February 28. IM

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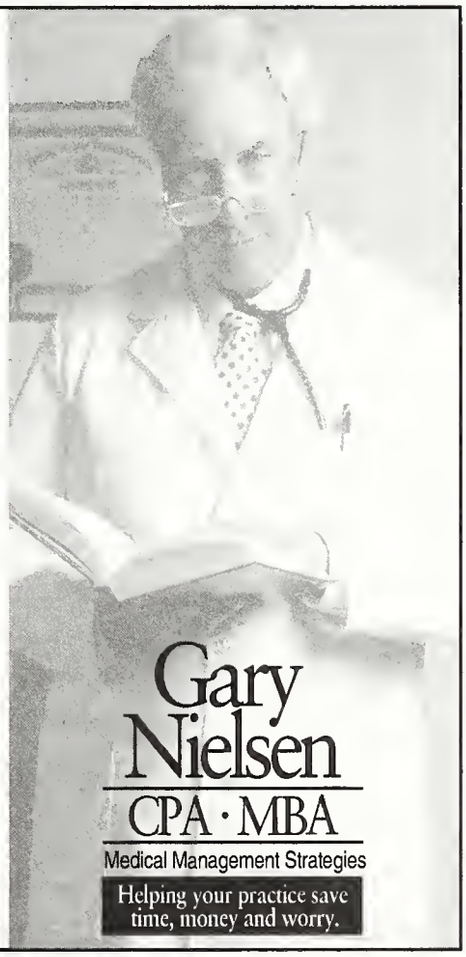
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Legislative Affairs

Principles of Agreement: Managed Care

For several months, IMS representatives have been meeting with representatives of third party payers in an attempt to create principles of agreement for managed care. These finalized principles — based on key elements of the AMA's Patient Protection Act — have been approved by the organizations appearing at the end of the document.

The listed organizations have voluntarily worked together to develop this cooperative agreement on principles to protect patients, physicians and hospitals under managed care. We believe the principles embodied in this document are in the best interests of Iowans.

Because our organizations represent a broad range of opinion, individual members of our associations may disagree with any policy or principle included in this document. We recommend and encourage physicians, hospitals and other providers who have differences with a managed care plan to pursue the remedies available to them through the mechanisms agreed to in these principles without relying on legislative remedies.

We recognize that because the health care delivery system is evolving so rapidly, these principles (many reflecting current practices) may not address all circumstances that may arise in the future. We recognize the rights of both managed care plans and providers to make business and economic decisions which reflect their concerns.

We believe the goal of all our organizations in agreeing to these principles is to provide high quality, cost-effective care to Iowans.

Principles

I. Advance Notice

Whenever possible, the listed managed care organizations agree to furnish notice three months in advance of the formation of any new provider network to provider trade associations representing the types of providers with which the managed care organization intends to contract. It is recognized that payers reserve the right to negotiate privately and reach agreement with a specific provider group in a local area in advance of providing such notice.

II. Opportunity to Apply

The listed managed care organizations agree to furnish applications to any requesting provider assuming there are openings in the provider panel, as determined by the plan managers. Applications will be considered for openings which occur within one year of the date of their application.

III. Selection Criteria

The listed managed care organizations agree to disclose the criteria by which providers are evaluated for network participation. However, proprietary information, such as scoring methodology, will not be disclosed with selection criteria.

Criteria for selection of providers into a managed care network will be disclosed to provider associations and will be furnished to individual providers upon request. The appropriate contact point within the managed care organization for providers who have questions about the criteria will be furnished.

Selection criteria should be objective and developed with provider involvement. Criteria may include geographic limitations, specialty limitations and economic considerations.

IV. Due Process

The listed managed care plans will establish a process where:

- Provider applications to a plan will be processed promptly.
- Providers rejected from a plan will be furnished reasons for rejection.
- A provider will not be terminated from a

AT A GLANCE

To date, the AMA's Department of News and Information has fulfilled 700 requests for House Speaker Newt Gingrich's speech to the AMA House of Delegates at the 1995 Interim Meeting. The AMA has prepared videocassettes of Joseph Cardinal Bernardin's speech to the AMA House. For more information on how to obtain copies of these tapes, call 312/464-4430.

The Kiplinger Newsletter *predicts continued high turnover in Congress, especially if there is no deal to balance the budget. Many GOP freshmen are vulnerable, he says. However, retirements will hurt Democrats, especially in the South.*

Wednesday, March 6 will be 'Medicine Day' at the Iowa Legislature—a day for Iowa physicians, spouses and clinic managers to see how the legislative process works. To register, call Paul Bishop or Lyn Durante at the IMS.

plan without notiee and an opportunity to appeal. No notice or appeal is required if there is imminent harm to a patient or there is a serious disciplinary action by the appropriate professional licensing board.

V. Freedom of Choice and Access

The listed managed care plans will have suffieient choice of providers to meet the needs of enrollees.

The listed managed care plans will provide sufficient geographic access to its enrollees within its service area. Whenever possible, primary care services will be available within 30 minutes travel time for the patient. Whenever possible, inpatient hospital care will be available within 60 minutes travel time for the patient. However, inpatient hospital services provided at a secondary or tertiary level are not limited by service area or patient travel time.

The listed managed care organizations will make alternative plans available to employers. These could include traditional indemnity plans, managed care plans or managed care plans with an out of network option. Plans with an out of network option may require additional enrollee copayments and deduetibles for out of network providers and/or a differential premium.

The following organizations have approved these guidelines:

Iowa Medical Society
Association of Iowa Hospitals & Health Systems
Blue Cross and Blue Shield of Iowa
Principal Health Care of Iowa
Principal Financial Group
SecureCare of Iowa, Inc.
Heritage National Healthplan
John Deere Family Health Plan IM

CONTACTING YOUR LEGISLATORS

Senators	**515/281-3371**
Representatives	**515/281-3221**
Governor	**515/281-5211**

Write to them at: STATEHOUSE, Des Moines, Iowa 50319

If you don't know who your legislator is or need your legislator's home address and phone number, call Lyn Durante of the IMS staff, 800/747-3070 or 515/223-1401.

Great Community
Great Opportunity

20-physician primary care group in Davenport has opportunities for high quality, motivated Family Practice and Internal Medicine physicians. If you are an effective utilizer who likes the stability of a group and who wants to be part of a dynamic physician-driven approach to care, send your CV to:

Mike Schreck, MD
Recruiting Director
3435 Spring Street
Davenport, Iowa 52807
or call 319/355-9191
fax 319/355-3419

WHAT WOULD YOU DO IF YOU COULD BUY TIME...



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Medical Economics

IMS files amicus in malpractice appeal

The IMS has filed an *amicus* brief in a medical malpractice appeal to be heard by the Iowa Supreme Court. The case involves two issues which have significant implications for all Iowa physicians.

Qualifications of expert witnesses

The first issue is of vital interest to all physicians — the qualifications of people who testify as expert witnesses in medical malpractice cases. At least one insurer — Midwest Medical Insurance Company — views this as the single most important issue in malpractice cases.

In the case, a certified registered nurse anesthetist (CRNA) testified as to the standard of care governing the surgeon being sued. The judge excluded the CRNA's testimony on the basis that the proposed expert was not a licensed physician.

The case was eventually settled in favor of the defendant physician and the plaintiff is appealing the ruling on the basis that the testimony of the "expert" witness should have been admitted into evidence.

The amicus brief filed by the IMS in the case supports the defendant's argument that Iowa law requires expert witnesses in medical malpractice cases to be physicians licensed in the same area of specialty as the defendant doctor.

Confidentiality of peer review records

A secondary issue in the case is that of the confidentiality of peer review records.

During the initial trial, records of peer review activity from the defendant hospital were admitted into evidence. The trial judge excluded the records from evidence on the basis that they are protected peer review records under Iowa law.

The plaintiff is now alleging that since the peer review records in question were not connected with any disciplinary proceeding, they do not qualify as peer review records and should have been admitted.

AT A GLANCE

Members of the IMS Board of Trustees were scheduled to meet with representatives of John Deere Health Plan on January 17 to discuss issues of mutual concern. Iowa Insurance Commissioner Therese Vaughan and Walt Tomenga, chairman of the CHMIS Executive Committee, were guest speakers for the January 18 IMS Executive Council meeting.

Nationwide, rural hospitals slipped behind urban hospitals in profit percentages in 1994, reports Modern Healthcare. *The data was taken from Medicare cost reports from 4,108 acute care hospitals over 25 beds or more. Other trends in the study showed that the fullest hospitals are the least profitable and that outpatient revenues account for 35% of total revenues.*

Justice Dept. appeals Dubuque merger

The U.S. Justice Department has appealed a federal ruling which allows the merger between Dubuque's Mercy Health Center and Finley Hospital to proceed. Both Mercy and Finley have filed cross-appeals.

Experts say the Dubuque hospital case is a significant one because a favorable ruling clears the way for other hospital mergers.

The two hospitals signed a merger agreement in February of 1994. The U.S. Justice Department brought an antitrust suit on the basis that the proposed merger would create a health care monopoly. The hospitals say the merger will control rising costs, increase efficiency and strengthen Dubuque's position as a regional health center.

The matter will now be considered in the 8th Circuit Court in St. Louis.

Tax changes taking effect this year

According to the *Kiplinger Newsletter*, due to the budget impasse there are lots of uncertainties about tax changes on the horizon. However, many changes are certain — revisions in standard deductions, personal exemptions and more.

The newsletter editors will send one copy of their *Tax Letter* free to anyone who sends a stamped, self-addressed, business size envelope to Gerry Moore, Kiplinger *Tax Letter*, 1729 H. St., NW, Wash., DC 20006.

FTC rules on CMA plan

The Federal Trade Commission has removed the last obstacle to the California Medical Association plan to enter the managed care market. The FTC rescinded a 16-year-old order barring CMA and its subsidiaries from developing or publishing physician reimbursement schedules or other relative value studies. IM

CHMIS Update

Delay in CHMIS deadline sought, task force appointed

In a special letter mailed in December to all IMS members, it was announced that the CHMIS Governing Board will recommend to the Iowa Legislature that the deadline for CHMIS implementation be delayed until July 1, 1997.

It was widely understood that CHMIS was dependent upon a financing model that could demonstrate a true savings in administrative costs within the entire health care system. Much of the costs associated with CHMIS are related to the operation of a data repository. CHMIS received bids from four companies to contract as the data repository — IBM, IFMC, NCS and Shared Medical Systems. Two of these bids were disallowed because they did not meet CHMIS criteria. The other two bids were much higher than the Governing Board anticipated.

The CHMIS Board compiled a new financing model based upon the two bids and concluded that the new model was cost-prohibitive and contrary to the CHMIS mission to save health care dollars. The Governing Board realized this was not acceptable and began to question whether there is enough interest to support a data repository.

The bids expire on February 15, which prompted the Governing Board to recommend a delay in the July 1 implementation date. By moving the target date to July 1, 1997, the CHMIS Board will have two legislative sessions to decide how CHMIS implementation should proceed.

The Governing Board has appointed a task force to study options for continuing the Iowa CHMIS program. The environment has changed since CHMIS was envisioned over three years ago. The task force will reassess the original CHMIS model. A range of options will be considered. The Board could decide to continue CHMIS as originally envisioned; a total repeal of the law is another option. Most experts believe the Board will eventually settle for something in between these two.

The task force is comprised of certain Governing Board members, key legislators and representatives of the various constituency groups as well as the Governor's office. Recommendations will be made to the full CHMIS Governing Board on February 16. Dale Andringa, MD, a member of the CHMIS Governing Board, has been appointed to the task force. Eldon Huston, IMS executive vice president, is also a member. IMS staff will be closely monitoring the task force activities and recommendations.

Though the Iowa Legislature is expected to agree with the Governing Board recommendation lawmakers may decide on another course of action.

For the time being, it is safe to assume that physicians need not contract with a network in order to send insurance claims electronically to insurance companies by July 1, 1996.

An article elsewhere in this issue describes the benefits of sending insurance claims electronically. While many physicians feel electronic claims submission makes good business sense, the mandate under CHMIS law is on hold for now.

For more information about these new CHMIS developments, contact Ed Whitver of the IMS staff, 515/223-1401 or 800/747-3070. IM

YOUR representatives on state CHMIS committees:

CHMIS Governing Board:

Dale Andringa, MD
Des Moines
515/241-4102

Beth Bruening, MD
Sioux City
712/233-1529

CHMIS advisory committees:

Communications/ Education
Laine Dvorak, MD
Clarenee Denser, Jr., MD

Data Advisory
John Brinkman, MD

Ethics/Confidentiality
Charles Jons, MD

Quality Review
Elie Saikaly, MD
William Langley, MD

Technical Advisory
Mark Purtle, MD

IMS CHMIS Committee:

Terrence Briggs, MD (chair)

IMS staff:
Barb Cannon
Ed Whitver
Dean Gillaspey

Practice Management

Physician sponsor praises MBS

Mark Menadue, DO of Acute Care, Inc. in Ankeny says that the job performance of a staff member is "tremendously more sophisticated" since she completed the IMS Medical Business Specialist (MBS) program.

Jill Caton of Dr. Menadue's staff was one of four recent MBS Certificate graduates pictured below who completed their certification work in December, 1995. Dr. Menadue said the MBS program "addresses the basic issues for overall understanding of the business of health care."

The IMS member survey conducted last fall documented member awareness of the MBS program and support of the value of the program. Based on the survey, two classes will be dropped from the requirements and two classes combined. One new topic will be added. The cost of the seminar classes will be lower during 1996. Details of the changes, plus the 1996 course schedule, will be mailed directly to IMS members.

Contact Sherry Johnson at the IMS, 515/223-1401 or 800/747-3070 for more information. IM

AT A GLANCE

Despite protests from over 50 national medical societies, HCFA has not been persuaded to delay implementation of its AdminaStar coding edits. They are effective as of January 1. However, HCFA acknowledges the codes have errors and promises to fix or remove code edits identified to them. Any IMS members having problems with the code edits are urged to call Barb Cannon at the IMS, 800/747-3070.

Physician Payment Reform repealed a Medicare law which said providers cannot bill the Medicare program a higher charge than any other payer. This means that an HMO, employee group or managed care plan may have a lower reimbursement rate than the Medicare fee schedule. For more information, call Barb Cannon at the IMS, 800/747-3070.



Recipients of MBS certificates are: (from left): Jill Caton, executive assistant for Acute Care, Ankeny; Marilyn Warwick, office/billing assistant for Dr. Richard Gannon, Grinnell; Connie Milligan, office manager for Kurt Vander Ploeg, MD, Pella; and Laina Small, office assistant with Grinnell Family Care.

Midwest Medical Insurance Company Focus on Risk Management

Breakdown in communication with patients

An internist examined a patient for complaints of a mass in her right breast. A needle aspiration yielded no fluid. He felt further examination was needed and intended to refer her to a surgeon following a mammogram. Unfortunately, he did not communicate this treatment plan to the patient.

The radiologist reported the mammogram results were suspicious for cancer and recommended a biopsy. Due to a clerical error, the mammogram report was sent to another physician with the same last name as the internist. The internist did not follow up with the patient to make a surgical referral and she never called back, assuming "no news is good news". Thirteen months later, she was examined by another physician and diagnosed with breast cancer.

This case illustrates why it is important to explain the treatment plan and the risk of not following it. Research tells us many malpractice claims could have been prevented with better communication. Breakdowns in communication about the potential seriousness of a condition may lead to the failure of the patient to follow up with the physician.

Decrease the risk of patient injury and malpractice claims by:

- Explain in words the patient can understand the treatment plan and the risks of not following it. Document the conversation.
- Establish office systems to track the return of reports, patient notification of results and follow-up of consultations.
- Follow up with patients who fail appointments for testing or referrals and reinforce the importance of follow-up care.

For further information, contact Lori Atkinson, MMIC risk management supervisor, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.



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Newsmakers

AT A GLANCE

Dr. Roger Ceilley, West Des Moines, was recently elected president-elect of the American Academy of Dermatology for 1996.

Dr. William Galbraith, UI College of Medicine internal medicine professor, has been selected as one of the 50 most positive physicians in the nation. Dr. Galbraith, a Cedar Rapids internist for 29 years prior to joining the UI staff, was nominated by Cedar Rapids Mercy Medical Center CEO and president A. James Tinker. He was chosen from over 300 nominees.

Awards, appointments, etc.

Dr. Nicholas Stanek, psychiatry and neurology, has joined Medical Associates Clinic and Finley Hospital in Dubuque. **Dr. Bruce Gantz**, UI College of Medicine professor of otolaryngology, has been appointed head of the Department of Otolaryngology, a position he had served on an interim basis since 1993. Dr. Gantz has also been installed as the 23rd president of the Association for Research in Otolaryngology. **Dr. Francois Abboud**, UI professor and head of internal medicine, has been named the first editor of a new journal, *Proceedings of the Association of American Physicians*. **Dr. Michael Welsh**, UI professor of internal medicine, is an associate editor. **Dr. Curtis Reynold**, Cedar Rapids, has been named director of Primary Care Services at Mercy Medical Center. Dr. Reynold previously served as director of the Cedar Rapids Medical Education Program and the Family Practice Residency Program. **Dr. Gordon Baustian**, Cedar Rapids, has succeeded Dr. Reynolds as director of both programs. **Dr. Andrew Patterson** has been appointed physician director of Mercy Care North in Cedar Rapids. **Dr. Robert Christensen**, Carroll family practitioner, was recently elected to the Carroll city council. Three physicians have been awarded John Deere Fellowships: **Dr. Billy Burge**, Waterloo family and emergency medicine physician, received the John Deere Health Care (JDHC) Managed Health Care Fellowship. The fellowship provides stipend support for a third year family practice resident to have a month long rotation in a John Deere Care Center. Family physicians **Drs. Viviana Martinez-Bianchi**, Iowa City and **Dr. Tammy Jo Wells**, Davenport, received JDHC Rural Health Fellowships. The fellowships provide stipend support for third year family practice residents to have a month long rotation with a JDHC-affiliated family physician in an area with a population of less than 15,000, but not designated as a shortage area. **Dr. Sonja Sather**, third-year resident at the Cedar Rapids Family Practice Residency Program, was one of the top 20 family practice residents in the U.S. to receive the 1995 Mead Johnson Award for Graduate Education in Family Practice. **Dr. John Ely**, Iowa City, was honored as the 1995 Medical Educator of the Year at the 47th Annual Meeting and Scientific Assembly. Dr. Ely was nominated for the award by his students and colleagues at the UI College of Medicine, Department of Family Practice where he has been an assistant professor since 1992.

New members

Elkader
Jonathan Knight, DO, family practice

Fort Dodge
Rosana Diokno, MD, pediatrics
Marshall Hunting, MD, general/vascular surgery
Ronald Sanders, Jr., MD, neurology

Harlan
Scott Markham, DO, family practice

Iowa City
Clayton Cowl, MD, internal medicine
Theodore Koerner, Jr., MD, pathology
Viviana Martinez-Bianchi, MD, resident
Steven Lillehaug, MD, anesthesia
James Skarda, MD, urology
Irene Sysel, MD, internal medicine
Lori Wenzel, MD, obstetrics/gynecology

Maquoketa
Roger Waller, MD, family practice

Marion
Barbara Barnett, DO, family practice
James Bell, MD, family practice
Richard Hodge, MD, family practice

Deceased members

Fred Hansen, MD, 90, life member, family practice, Red Oak, died November 26

George Skorcy, MD, 71, radiology, Sioux City, died October 3 IM

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An Iowa experiment
COMPUTERIZED patient records

Computerized patient records are the wave of the future in medical practice automation. This article describes 'Project CPR', a study of how physicians in three Quad Cities practices reacted to computerized records.

Most physicians are accustomed to — and comfortable with — a desk strewn with charts, each plastered with colorful notes reminding the physician to call in prescription refills or to contact Mr. Smith's son about his father's forgetfulness. Will these same physicians bring themselves to sit down at a console and click on an icon that lists lab test results and phone messages?

That's what Comprehensive Health Administration's 'Project CPR' (computerized patient records) was designed to find out. Three Quad Cities medical practices, under the guidance of the ISYS Group (formerly Healthcare Software Solutions) of Des Moines are serving as pilot offices where hypotheses about physician work habits can be tested without blowing up the whole chem building. The offices included my primary care practice, a consultative practice (Kathy Weideman, MD, Davenport) and a surgical practice (Orthopaedic Surgery Associates, PC, Daven-port).

Hypotheses about physician work habits can be tested without blowing up the whole chem building.

Making the case for computerization

Major trends in practice management are driven by a number of forces and the CPR is no exception. Reasons to go paperless include the cost of storing paper charts, relief for overburdened office staff, third party review demands, interchange of data with other physicians and the desire to study practice patterns within the practice. It should also be noted that most major carriers of medical malpractice insurance are studying the relationship of computerized patient records and malpractice claims. One of the major factors making computerization possible is the declining cost and increasing power and storage capacity of

WILLIAM LANGLEY, MD
Dr. Langley is a Rock Island family physician, an IMS member and medical director for Comprehensive Health Administration, Inc., a 400-physician group in Davenport which contracts with payers and offers a variety of member services.



Computers as a Tool in your Medical Practice

Ed Whitver, MBA, Health Care Data, Information and Services Manager for the Iowa Medical Society

Computers have become an integral part of our society. Applications for computers are increasing daily. This is especially true in health care, where medicine has been finding many innovative uses for computers.

The arguments against having a computer in your practice are rapidly deteriorating.

The Community Health Management Information System (CHMIS) law required all physicians to send insurance claims electronically to insurance companies. While the CHMIS Governing Board is recommending a one year delay in the mandatory implementation of CHMIS, many components of the CHMIS law are still beneficial to physicians. Computers and electronic data interchange (EDI) are tools that will eventually become a vital component of every medical practice.

The cost of personal computers (PC) has dropped dramatically, while their speed and capacity have increased significantly. A physician can purchase a new pentium PC with one gigabyte of disc storage and a quality laser printer for under $3,000. With software such as Windows 95, computers are easy to use. The arguments against having a computer in your practice are rapidly deteriorating.

Automate billing process

Probably the most common use for computers in the physician practice is to automate the billing function. Practice management software can be purchased for $3,000 and up, and like everything else, you get what you pay for. A quality software product like the IMS-endorsed AMOS system costs under $8,000 for a four-physician group.



Probably the most common use for computers in the physician practice is to automate the billing function.

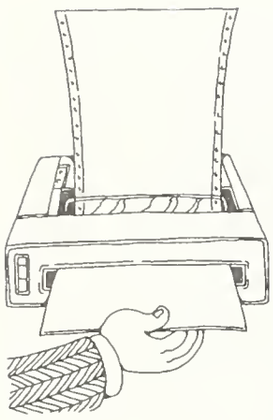
By automating the billing process, office staff no longer need to manually post charges and payments to ledger cards, along the way making mathematical mistakes, losing ledger cards, typing insurance claims and photocopying ledger cards to send to patients as a monthly statement. All of these functions are very labor intensive and have few checks and balances.

Practice management software streamlines all these functions. Patient demographic and insurance information are entered on the computer once. Changes can be made at any time. When the charge for a patient encounter is entered on the computer, an insurance claim and monthly statement are generated automatically. Daily reports help office staff verify that all

patient encounters were added to the computer and that payments posted to patient accounts match the bank deposit. This translates to fewer lost charges, increased revenues and better internal controls.

Generate computer reports

Many reports can be generated from computers. A detailed report of accounts receivable is available at any time with the push of a button. Reports can be printed which tell you what percent of your patients have Medicare, Medicaid, Blue Shield, HMO/PPO, etc. Collection efforts are greatly enhanced. The physician has access to a wide variety of data which describe the practice in detail, creating a physician-specific profile report.



The physician has access to a wide variety of data which describe the practice in detail, creating a physician-specific profile report.

The physician can use this internally generated profile in a variety of ways. Many insurance companies and health systems use profiles to select or exclude physicians from their provider panels. Physicians can use their own profiles to validate or contradict information produced by outside entities and offer more comprehensive and accurate information. Your computer generated profiles can also be utilized to compare with your peers and identify best practices and benchmarks. This will help you identify areas where your practice can be improved and sends a signal that you would be a valuable participant in any health system.

The real advantages of computerization can be realized with electronic data interchanges. Many studies have shown that electronic insurance claim submission saves money compared to paper claim submission. This cost reduction benefits both the provider and the insurance company.

Inexpensive software allows the physician to send an insurance claim electronically to more and more insurance companies. Various edits are done before claims are transmitted, ensuring that all required data are included so the claims are as accurate as possible.

Sending a claim electronically means the claim can be received by the insurance company the same day the service was rendered. The claim should be considered "clean" (no errors) and processed faster by the insurer. Theoretically, the claim should also be paid much faster, reducing the physician's accounts receivable.

Electronically verify insurance coverage

Electronic insurance claim submission is just one of many electronic transactions that will benefit the medical practice when computers are added. Office staff can access the computer system of a patient's insurance company to electronically verify insurance coverage. This inquiry could verify that the patient is a covered member of the insurance policy, the effective dates of the policy, how much of the deductible has been met for the year, the patient's co-pay for the service, if the procedure being performed requires pre-authorization, whether coordination of benefits is required and many other functions. Electronic insurance eligibility verifi-

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cation is a great tool to help office staff collect money at the time of service.

In an electronic environment, the insurance company can electronically transfer payment for the insurance claim directly to the physician's bank. Some systems will also post the payment directly to the patient's account on the physician's computer, reducing staff time devoted to this time-consuming function. Electronic funds transfer (EFT) speeds the receipt of cash to the physician office, further reducing delays inherent in the mail system.

One drawback for electronic claim submission has been that insurance companies require various types of supplemental information with the insurance claim form. This, too, can be accomplished electronically. National standards are currently being developed for the submission of supplemental information, such as operative reports, progress notes, radiology interpretations, etc.

of CHMIS is al intent to nation ls of health able goal. n should rtant tool to improve livery.

Automate patient records

Perhaps the most advanced use of computers in the physician office is to automate the patient medical record. Excellent computerized medical record software packages such as the IMS-endorsed MR2000 from the ISYS Group are available at various prices. Many of these software packages include a decision support system which reminds the physician to obtain a social history, cross-check drug interactions, review lab results, etc. Many products can easily be used with the patient in the exam room without distracting from the patient/physician interaction.

Computerized medical records have many advantages over paper records. They don't get lost, misplaced or misfiled—a common anomaly in any physician paractice. Prescriptions and patient instructions can be printed from the computer, reducing errors from interpreting handwriting. Lab and radiology orders can be sent to other providers electronically and results received the same way. With a computer installed at home, physicians on call for their partners can have access to the medical records of all patients in the practice, improving the delivery of care during "off" hours. Entries in a computerized medical record are usually more accurate, timely and thorough, a comforting thought if the physician must defend the patient record in a court of law.

Electronic transactions through the use of computers can save the physician and office staff time and money. Though the future of CHMIS is in doubt, its original intent to integrate automation throughout all levels of health care remains a viable goal. Today's physician should embrace this important tool and use computers to improve health care delivery.



Computerized medical records have many advantages over paper records. They don't get lost, misplaced or misfiled.

Turn the page for valuable tips on selecting a network vendor.

Tips on Selecting a Network Vendor



When selecting any business partner, there are several important questions to ask. The contractor should have financial stability, several years experience performing the proposed service, a willingness to furnish customer lists to check references, etc. A few other unique inquiries should be discussed before signing a contract with a network vendor to provide electronic insurance claims submission.

1 Electronic physician insurance claims must be submitted using either the National Standard Format (NSF) or American National Standards Institute (ANSI) X.12 837 formats. Both standards have been accepted by Medicare, HCFA and CHMIS. Make sure your network is sending claims in one of these two formats only.

2 There are many variations in how networks charge for electronic transactions. Some charge per claim, others charge a flat rate per physician per month. Analyze which method would be most cost effective for your practice. Ascertain if there are additional ongoing charges such as software maintenance and upgrades, etc. and how many times per year these changes are provided.

3 Many networds offer other 'value added services' (VAS) such as electronic eligibility, electronic funds transfer, logical editing, etc. Usually there is a charge associated with each VAS, but some networks may include them in the quoted price. If you do not want access to value added services, make sure you are paying for claim submission only. Otherwise, obtain several quotes from various networks to find the best package of price and options for claim submission and value added services.

4 Some networks accumulate certain data from claims sent by all providers to build a data base. This data base is offered to physicians as a value added service by generating individual physician profiles, comparisons to peer groups, data analysis, etc. If you do not want the network vendor to collect your data in its data base, make sure this is specified in the contract.

5 Usually, network vendors must install additional software on your computer to send your insurance claims electronically. Not all network software can easily interface with your practice management software. Clarify up front what must be done to make the network software compatible with your current software and determine a price to interface the two software products.

6 Your network vendor should have existing contracts with other Iowa physicians. Many network vendors provide services to hospitals, which obviously use a different insurance claim format. Do business with a network vendor that has physician clients, preferably from Iowa.

7 Though the CHMIS mandate is on hold, physicians should not ignore the law. Include an immediate cancellation clause in the contract if the network vendor fails to become a certified CHMIS network. At a minimum, include a 60 or 90-day cancellation provision.

Obtain several quotes from various networks to find the best package of price and options for claim submission and value added services.

today's computer systems.

Most CPR systems available will store and print typed or dictated text, lab results, prescriptions, referrals, problem lists, family and surgical histories and phone messages. Once approved or "electronically signed" by the physician, the data is frozen so it is every bit as legal as an entry in a paper chart.

'We've always done it this way'

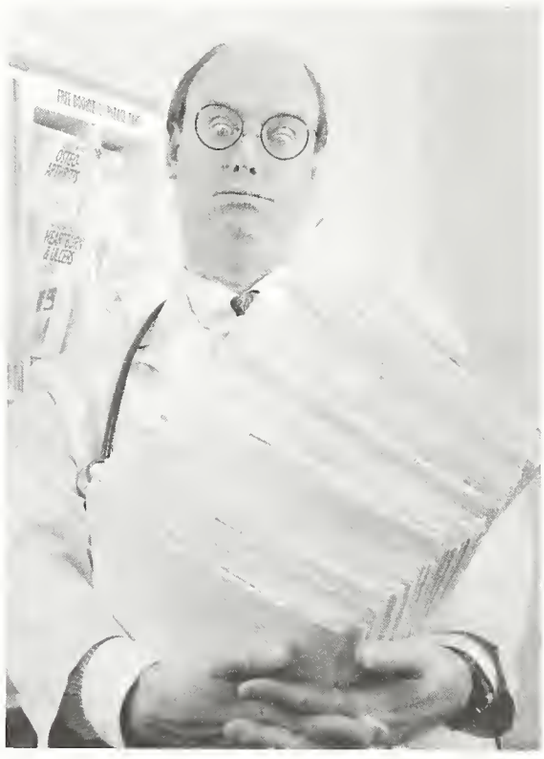
Our three pilot offices were selected because these six words were not in their vocabularies. Introducing a completely new technology into a setting where a fax machine might have caused consternation would be asking for a system crash.

The old ways are devilishly effective. Using a large pile of charts to get the doctor's attention seems to work. However, the most important issue is whether a pop-up list of tasks on a screen could get the job done more efficiently. Also, the computerized chart is simultaneously available to others.

Frank Lloyd Wright vowed to "open up the box" of Victorian houses by challenging all of the architectural tenets of the day; because of his radicalism, we now take it for granted that the rooms in our homes flow from one to another rather than all branching from a formal hallway. Computerized charting affords each office the same chance to reengineer its procedures.

System rapidly became second nature

Implementing the CPR in the three clinics took a concentrated effort by all staff members and the desire to use the system to its fullest extent within a minimal time period. Subsequently, after completing a concentrated training course on the system, we jumped in with both feet and began using almost all of the functionalities of the system right in our exam rooms from the outset.



This probably slowed our staff members down initially while they became familiar with the ins and outs of the program, but they became comfortable with the system rapidly and we experienced the benefits of computerized patient information within a few weeks. Using the system has become almost second nature to us now.

Patients adapt readily

One of the questions we were most anxious to answer was how patients would respond to the idea of computers keeping their medical records. So far, all three offices participating in the pilot program have reported a high degree of patient acceptance.

Many patients ask if their records are still confidential and some ask if we back up the information stored in the computer. (Full back-ups are done daily and the previous day's tapes stored in another location. The

Many patients ask if their records are still confidential and some ask if we back up the information stored in the computer.

records are probably more secure than their paper counterparts, which could be destroyed if the office were to catch fire.)

Maintaining eye contact with the patient rather than the computer screen is an acquired skill just as it is with a paper chart.

Passwords required to view record

With regard to confidentiality, passwords are required to view the record and printouts or electronic transmission of parts of the charts are released only with patient permission. It has been helpful to point out to patients that being on a computer system is not necessarily the same as being on the Internet.

Dr. Weideman and I have taken this patient-friendly approach a step further and have computers right in the exam rooms, using the record as a teaching tool by pointing out medications and test results. Small, quiet bubble jet printers also print out prescriptions and patient education material so that when the patient leaves the exam room, the clinic note is written, any prescriptions ordered are printed and the coding is complete. The screen can be locked to prevent patients from browsing through other patient records.

Maintaining eye contact with the patient rather than with the computer screen is an acquired skill just as it is with a paper chart.

Happy with results

We have had the MR2000 in our clinic for over five months and have been very happy with the program. We are building a clinical data repository which can help us study our practice patterns and are using our time and resources more efficiently.

By completing the note for the chart and coding for billing at the time of the visit, the encounter is truly complete by the time the patient leaves our office — no more nights spent reviewing or dictating over a pile of backlogged charts or time spent looking for lost or misplaced charts.

Currently, we are anticipating completion of an interface between the MR2000 and our practice management system. This will allow all of the billing information for a patient visit to be passed directly to our practice management system with the stroke of a key or click of a mouse. IM

The ISYS Group is a subsidiary company of Blue Cross Blue Shield of Iowa and is endorsed by the Iowa Medical Society. For more information about the MR2000, call John Houge at 515/237-6610.

About the record system for Project CPR

The record system selected for project CPR was MR2000, a comprehensive software program which includes a summary screen which displays pertinent data to the provider regarding the patient chart and medical history. It contains complete patient demographic and historical information, notes of each patient encounter, pharmaceutical records, lab results, referral and consultation information and more. All data within the record can be presented on the screen or in a printed format.

An in-house administrator identified work patterns in the three practices participating in the pilot project and worked with the ISYS Group staff to customize data screens and printouts. As the doctors, nurses and reception area staff began using the system, further modifications were made to fulfill their requests for uses of the system.

One Iowa data study . . .

C-section rate can be reduced

The cesarean section rate in Iowa can be safely reduced below its current level, but no one knows the optimal goal for reduction.

That's the major conclusion of a recently-completed study of c-section rates in Iowa hospitals.

Cesarean section rates have been the focus of numerous studies over the past decade. Many states, insurers and hospitals have begun to address cesarean sections as part of their objectives for improved health care delivery.

In November of 1994, the Iowa Health Data Commission (HDC) authorized a study of whether disparity among Iowa hospitals in cesarean section rates was significant enough to warrant a report. The Iowa Medical Society was represented on a panel of experts advising the HDC and the Iowa Department of Publie Health on the study. (Ted Haas, MD, an Ottumwa obstetrician and Douglas Stanford, MD, a Waterloo obstetrician, represented the IMS.)

Data for the study was gathered from all Iowa hospitals. The study found that the average c-section rate in Iowa is lower than the national average and has decreased during the past two years. The characteristics of patients receiving c-sections match those found in national studies. Medical indications are also similar to those identified in national and international studies.

Significant eharacteristics predisposing for cesarean delivery included increased maternal age, increased education level, private insurance, multiple birth, primipara and smaller hospitals.

There is no scientifically established "optimum" cesarean section rate. It is not known at what point outcomes are maximized. Also, differences in cesarean section rates are probably due more to differences in practice patterns than in any large difference in patient risk factors.

Because there is no optimal goal for reducing the number of c-sections, the expert panel recommends each hospital and medical staff review their own data, identify areas to address, evaluate current practices and implement appropriate changes.

The two areas with the most potential for reduction are "active management of labor" and vaginal birth after cesarean (VBAC). In particular, increasing the VBAC rate could have a significant impact on cesarean rates.

Two areas with the most potential for reduction are "active management of labor" and vaginal birth after cesarean.

The expert panel recommends three "action steps" to reduce cesarean rates:

•Hospitals should compile their own cesarean rates by physician on a regular basis and circulate the information among the medical staff.

•Professional associations should play a significant role in educating hospitals and physicians.

•Patient education regarding VBACs should begin as soon as possible. The Department of Public Health plans to provide patient education pamphlets about VBACs. They would be given to patients after a cesarean delivery.

For more detailed information regarding the Iowa c-section study, contact Ed Whitver of the IMS staff, 515/223-1401 or 800/747-3070. IM

CME Seminars

AT A GLANCE

Advertise your continuing medical education seminars or workshops in this section by calling Jane Nieland or Bev Corron at the Iowa Medical Society, 515/223-1401 or 800/747-3070, fax 515/223-8420 or send copy and payment to Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265. Cost is $25 per insertion up to 10 lines. Deadline is the first of the month preceding publication.

General Interest

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April 17, 1996—8 a.m.–12:30 p.m.
Mercy Education Center
$50, 4 credit hours
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Contact Medical Education: 515/247-3042

Surgical Symposium on Laparoscopic Procedures
April 19-20
Iowa Methodist Medical Center, Jester Auditorium, Des Moines, Iowa
$150 physicians, $35 residents, 10 credit hours
Contact Surgery Education Office, Iowa Methodist Medical Center: 515/241-4076

Neurology

Current Clinical Challenges with Difficult-to-Treat Psychiatric Disorders
March 16, 1996
Ritz-Carlton, Kansas City, Missouri
$75, 5 credit hours
Speakers: Glen Gabbard, MD; John H. Greist, MD; Del Miller, PharmD, MD and Mauricio Tohen, MD, DrPh
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The Journal
of the Iowa Medical Society

Health management data sets: benefits (and risks) for physicians

● ROBERT REITER, MD

Large clinical and administrative data sets permeate our health care system. The Uniform Hospital Diseharge Data Set databases (UHDDS), PRO (Peer-Review Organizations) databases, Public Health Service (including reportable disease) data sets and population registries have been maintained for decades. These data sets have facilitated (with arguable degrees of success) functions ranging from billing and reimbursement to practice profiling, quality assessment and population-based disease management. Few physicians would argue with the benefits of an efficient, standardized administrative data set supporting business-related health care functions.

Beginning in the early 1970s, we witnessed the first large scale attempts to utilize administrative data sets for the purpose of assessing health care quality. Utilizing hospital discharge data, Wennberg and associates published widely publicized "small area analyses" demonstrating dramatic variation in utilization of various procedures within small geographical regions.[1] In many ways, these reports inaugurated the "modern" health care reform debate in the U.S.

Over the past two decades, there have been numerous attempts to optimize the utility of these administrative data sets, including development of elaborate severity adjustment models utilizing sophisticated multivariate statistics. The hoped-for goal of these severity adjustments was to allow for comparisons of "apples and oranges;" that is, comparisons of dissimilar populations which may vary due to severity of the condition of interest or due to comorbidity (concurrent diseases or chronic conditions such as diabetes) which may adversely influence outcomes independent of treatment effects. Utilizing these data sets, several states (including somewhat infamous experiences in New York state and more recently in Pennsylvania) have published either severity-adjusted or crude mortality and utilization rates of various procedures for both hospitals and individual providers.

Unfortunately, these data sets are fraught with limitations. First, they were originally designed to support billing functions rather than comparisons of health care quality. Secondly, substantial controversy persists regarding the actual significance of small area variation, with some researchers claiming that they do not necessarily reflect inappropriate utilization.[2] Third, although there are a half-dozen widely utilized severity adjustment models, the correlation between these models is alarmingly poor and none have been objectively demonstrated to be more statistically valid than the others. Finally, large data sets are notorious for high variation in data quality owing in part to variation in coding practices and skills.

Attempts to standardize data

In an attempt to address many of these concerns, many states, including Iowa, have embarked on initiatives to standardize health management data, improve data quality and increase access to data by potential users. The Iowa Community Health Management Information System (CHMIS) is attempting to improve both the quality of administrative data as well as to supplement them with quality related data including patient satisfaction, health status and clinical outcomes. The Iowa CHMIS, which was originally scheduled for implementation in July 1996, will likely be delayed for at least one year because of con-

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for February 1996.

ROBERT REITER, MD
Dr. Reiter is an associate professor with the University of Iowa College of Medicine and director of Outcomes and Evaluation Management, UI Hospitals and Clinics.

Health management data sets: benefits (and risks) for physicians

continued

cerns by the CHMIS Governing Board regarding prohibitively high cost. However, even in states without CHMIS initiatives, similar projects are being spearheaded by purchaser and payer communities in hopes of facilitating contracting between competitive health plans and provider groups. It seems clear that health management data sets will continue to be integral to our health system and will become an increasingly larger part of our professional lives. The utility of these data to purchasers, researchers and even consumers is readily appreciated, as are the potential risks to providers, given the caveats and limitations noted early. We have witnessed medical, legal, quality assurance and administrative misadventures which have resulted from inappropriate interpretation of data or poor quality of data.

Given this rather cautionary context, what are the potential benefits to providers of such data sets? Experience in health systems with advanced health management information systems suggests there are concrete benefits which physicians may derive from such data sets, provided that certain criteria are met. These critical success factors would appear to include:

- minimizing supplemental data collection burden by identifying so-called "minimal" data sets;
- development and enforcement of minimal standards of data quality;
- use of consistent severity adjustment methodologies; and
- providing timely access to data, including development of standardized simple report formats.

Clearly, these criteria are not automatically or readily attained, but must be met if any substantial benefit is to be realized.

Benefits for physicians

Early benefits to physicians associated with health management data sets are commonly in the realm of improved billing functions (see the insert by Whitver, in this issue of *Iowa Medicine*). In more advanced markets, benefits have included increased competitiveness for managed care awards. Data regarding utilization of procedures, ancillary services and consultants; cost; length of stay; and patient satisfaction have been increasingly utilized as bases for inclusion of physician and physician groups into provider panels and selective service contracting. As revenue centers shift towards cost centers under managed care, these data remain equally critical in order to identify opportunities for cost reductions and negotiate capitated payments.

An additional benefit of participating in larger data sets is benchmarking; i.e., comparison of one physician's performance with that of peers. Large health management data sets allow for comparisons of a variety of indices of both effectiveness (quality) and efficiency of care. The purpose of benchmarking is to measure one's performance relative to specific standards such as median, 75th, 90th and "best-practice" among local market, statewide or national comparisons. Examples of quality related data elements frequently utilized in benchmarking include severity adjusted mortality, risk profiles (e.g., post-op infection rates) and patient satisfaction. Examples of efficacy related benchmark parameters would include severity-adjusted charges, cost, length of stay and utilization of ancillary services.

When integrated, these analyses can provide an objective basis for value management, process changes targeted at optimizing the quotient of effectiveness (quality) and efficiency (minimizing cost and resource use).

The literature is replete with accounts of provider groups and hospitals who have used these data sets to successfully identify targets for specific clinical and operational process improvement interventions designed to improve outcomes, reduce cost, or both.[3] These process changes may take the form of improved coordination of services, elimination of redundant or unnecessary services or processes, or development of consensus- and outcomes-based practice guidelines.

A third widely anticipated benefit of health data management is real-time clinical decision support. Visions for this goal range from immediate on-line access to drug information, accepted practice standards and medical literature relevant to a given patient, to a fully integrated computer-based patient record with instantaneous access to trended long-term diagnostic, resource and outcomes data which may be accessed fiberoptically

across the entire continuum of care. While the latter may be realized a decade or more in the future, the former is currently available in many community hospitals and multispecialty group practices. The force with which physicians embrace (or resist) these efforts will likely prove the rate limiting step in the evolution of systems such as these which hold the greatest potential for physicians and patients.

Health status surveys controversial

A hotly debated question regards the use of so-called health status surveys such as the medical outcomes survey SF-36 or SF-12.[4] These generic self-reported measures assess dimensions of health such as physical and mental functioning and the impact of illness and treatment on these functions. While they have demonstrated utility in predicting resource use and documenting medical treatment effects in populations, their use in individual patient care remains controversial. Many clinicians are currently piloting these assessments in actual practice and attest favorably to their value. If they are indeed demonstrated to be of value in individual patient care, health status assessment may prove to be the most logical next step in development of supplemental outcomes data sets, after patient satisfaction.

Several preliminary studies have suggested that baseline health status may turn out to be a simpler and more accurate tool for severity adjustment than many of the statistical models currently in use. If this is the case, this advantage alone would argue strongly for continued development and integration of these measures.

A final but practical and compelling benefit to physicians for participation in statewide health management data sets is that they may provide a critical check for the myriad of electronic profiles by which physicians will be increasingly compared and scrutinized. The availability of a comparative analysis derived from a high quality widely-accepted statewide data set may prove invaluable to a physician attempting to objectively address concerns with data reported by payers or purchasers, or by the media.

In summary, we are in the midst of an era characterized by multiple paradigm shifts — from fee-for-service to managed care, from authority-based to evidence-based practice and from physical to "virtual" documentation and health information management. Physicians, as critical thinkers and primary advocates for their patients, welcome these shifts to the extent that they are associated with benefits to their patients, society and the medical profession. The overwhelming momentum favoring change in this arena will inevitably bring both risks and benefits. In the long run, physicians must embrace these changes if they are to realize substantial benefit from them, and if they are to assume leadership in the processes which will determine the direction, scope and speed of these changes.

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We are surrounded by violence

It's in our homes, our schools, on the streets, in television programs and advertisements . . . we are surrounded by violence. We have addressed domestic violence in previous issues of *Iowa Medicine*. Our medical society has made available audio tapes and literature in the struggle to eliminate this social blight. Likewise, many other journals have devoted editorial space to this subject. Yet, Americans continue to be bombarded with evidence of violence, both direct and indireet. Unfortunately there are many who accept violence as a norm.

Recently there appeared on television an advertisement depicting a young lady speeding down a highway in her new Camaro. As she forcefully shifts gears to go faster and faster, each step is accentuated by a statement of violent connotation. "That's for my no-good ex-husband!" "That's for that inconsiderate bank clerk!" "That's for the lousy coffee served by a snippy waitress!" Then, as she passes a gasoline tanker-truck she has her hand out the moon roof of her automobile and cries out "And, that's for you!" We cannot see the configuration of her hand but could assume her third finger is extended in an indecent posture. What an example to set for others!

Unfortunately there are many who accept violence as a norm.

Television ads promoting various computer games often are of violent persuasion. Many toys for small children promote violent acts, e.g. simulated car crashes, shooting games, etc. What has been noticeable to me is that toys for boys often depict mainly macho, albeit violent behavior. However, toys for girls depict wholesome activities of child care and non-violent group activities as in Barbie ads. Now, before certain groups get on my case, I do not imply all girls activities must be of a domestic theme; just discontinue the active and passive violence in advertising aimed at boys.

Parents must be aware what their children are viewing. True, much is make-believe; we adults must point that out to our children so they know such is not accepted behavior. Furthermore, adults must develop renewed concepts of activity and entertainment that eliminate the need for violent expression. Parents as responsible adults must have control over that to which their children are exposed. Positive dialogue with children is mandatory to help them grow in an environment of love and responsible behavior. All this takes foresight and much effort, but it is worth so much to all . . . the adults as well as the children.

May there be a day when common consensus will demand that we can live in a world of peace without violence, whether it be between nations or individuals. IM



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The physician workforce in the next century

For several decades considerable effort has been expended to predict future physieian workforce needs in the United States. Within recent months well-publicized studies have suggested the possibility of emerging physician surpluses, surpluses that could result in diminished productivity, loss of physician income and even unemployment.

In an article in *JAMA*, Cooper has provided a useful construct for evaluating this issue (274:1534, November 15, 1995). He suggests that the workforce requirement should be defined by three faetors: physician utilization in group and staff-model health maintenance organizations, physician distribution and the future supply of nonphysician clinicians. Mathematical projections using these factors predict a surplus of 62,000 physicians (8% of practicing doetors) by 2010, with a subsequent narrowing of the supply in contrast to demand.

This projection is not as dire as others, but confirms that physician demographics will continue to be a major faetor in shaping the health care delivery system. Cooper's analysis has significant implieations for states such as Iowa. Our state's physician cohort closely models the national norm for physician demand, estimated to be 205 physicians per 100,000 population. This statistic translates into continued opportunity for physicians in our state, especially in primary care. It also suggests that Iowa will continue to be a magnet for physicians seeking relocation opportunities from states that are "oversupplied."

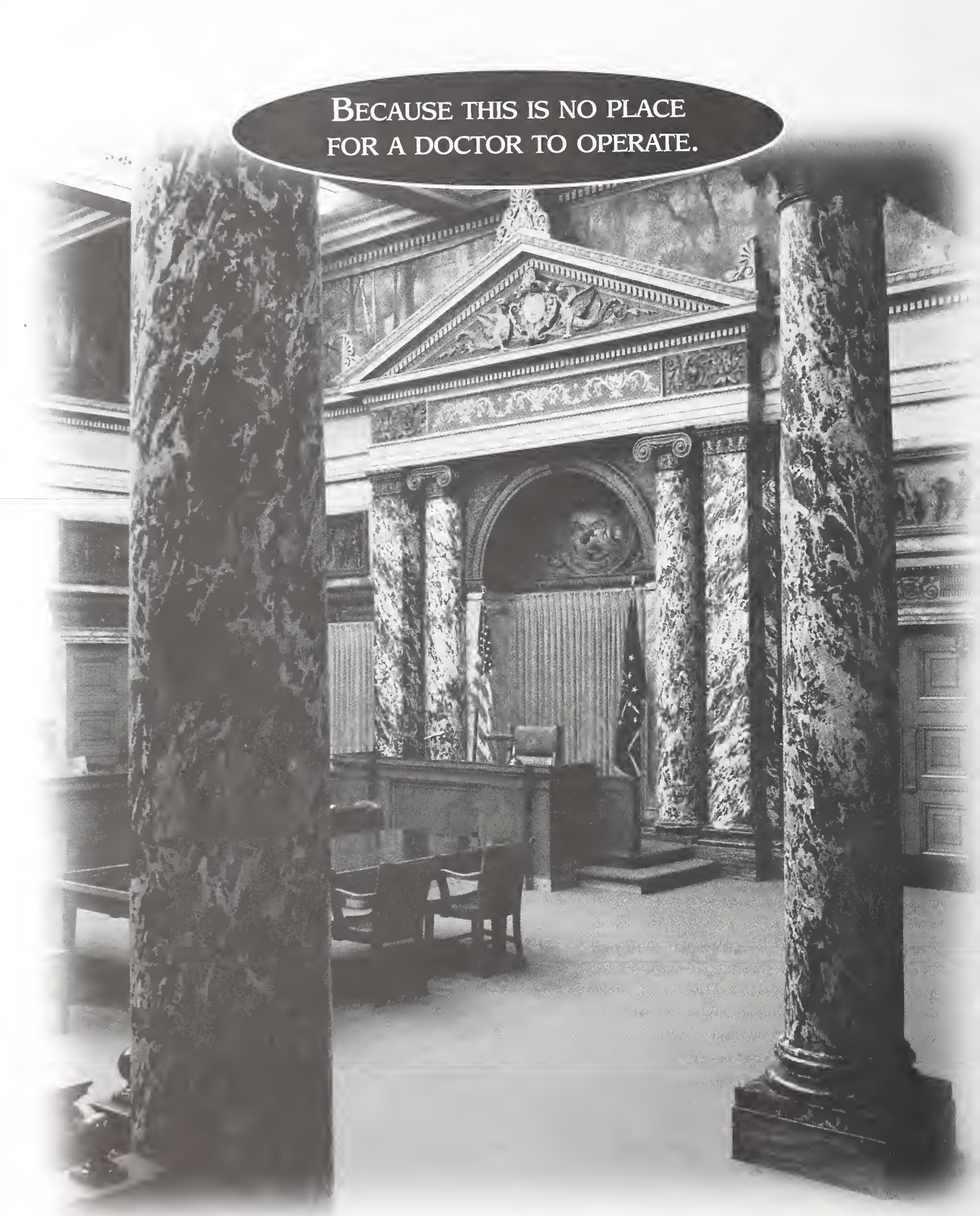
Physician demand is not only determined by the size of the population, but its nature as well as other health care resources available to address needs of people. Again, Iowa has special demand features which include a disproportionate number of elderly persons who require greater than average health care and a dispersed population which utilizes decentralized health care resources, expecially for primary care. The rural character of much of the state also justifies the development of networks that employ physicians in an appropriate specialty mix and the use of other health care practitioners, especially physician assistants and advanced nurse praetitioners.

Physicians may not have the option of concluding that they do not need to know or do something.

What have these workforce issues to do with continuing medical education? A great deal. As physicians increasingly become part of health care systems, their responsibilities will of necessity complement those of colleagues. Physicians may not have the option of concluding that they do not need to know or do something because patients will have access to care elsewhere. That care may have to be provided by the physician in question. For many of us it is time to search the Internet and CME course directories for what we need to be contributing members of the 21st century workforce. IM



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Iowa Healthy Kids Project

Thanks to Steve Jacobsen, president of Employee Benefits Services Inc., a program to benefit the health of uninsured and underinsured children was introduced to several influential people in Iowa.

The Healthy Kids Program was begun in Volusia County, Florida in 1990 and has grown to cover more than 13,000 school children in several of that state's counties. State Senator Elaine Symoniak felt this would be an excellent program to help an estimated 65,000 uninsured Iowa children who are not eligible for Medicaid—the children of the working poor.

A Healthy Kids Board of Directors has been formed and has met twice to discuss strategies for implementating an Iowa Healthy Kids Program. Funding, of course, is a most important problem. The program's originator believed school systems eould be used as an insurance grouping mechanism to ascertain underwriting information and that private health insurance carriers could administer the program on a capitated basis.

Most health insurance carriers create premiums based on underwriting principles whieh include the size of the group. With larger businesses and large numbers of employees the risk is spread, reducing the cost per employee. School systems could be used to create large groups of participants, just as the large businesses do. In other words, school children would become "employees".

Administrative costs will be kept at a minimum and actuaries are adept at figuring medical costs in the school ages to be covered, i.e., 5 to 19. (It has been found that school age children are basically healthy and relatively inexpensive to insure.) As a matter-of-fact, it costs less per day to provide comprehensive health benefits to school children than it does to serve them lunch.

Conclusion: Iowa Healthy Kids Program will be a non-political comprehensive health insurance product for school children who are underinsured or uninsured. It is the hope of the Board of Directors that there will be a total cooperative effort from Iowa physicians in this endeavor. There will be further information concerning this program in future issues.

In other words, school children would become employees.

For further information please contact Steve Jacobsen; 515/223-9878 or 800/778-9878.

(Presently there are three Iowa Medical Society physicians on the Healthy Kids Board: Rizwan Shah, MD, David Carlyle, MD and Don Green, MD.) IM



DON GREEN, MD

Dr. Green is a family practitioner from Des Moines and medical director for Des Moines schools.

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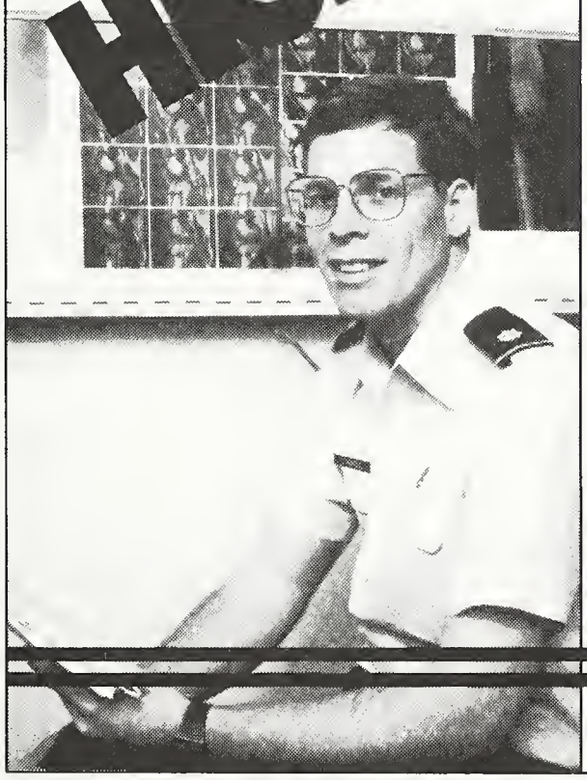
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(Continued next page)

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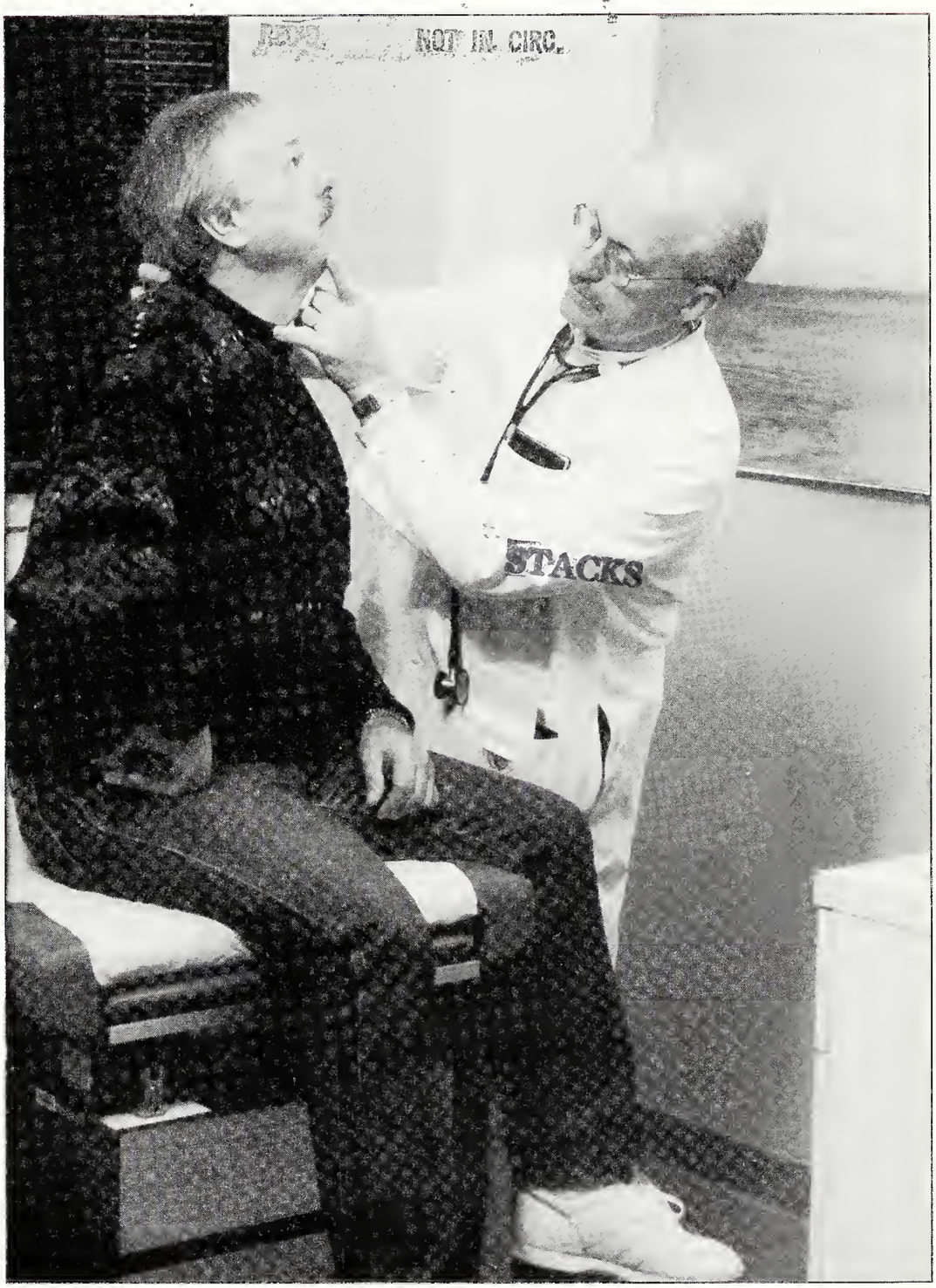
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Coping with the government's increased health care investigation and coding audits
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Task force recommends CHMIS data repository be abandoned
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Managed care — What's going on right here in Iowa?
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IMS *DEADLINE* news

MARCH, 1996

Late-breaking news of interest to Iowa physicians

●**MEDICARE'S ADMINISTAR "CORRECT CODING" INITIATIVE** began January 1 and is causing big problems for some Iowa physicians, particularly those who don't participate in Medicare. IMS staff are receiving numerous calls from physicians who have received reason code 098 denials due to the Administar initiative, which HCFA projects could save $640 million this year. Unfortunately, the AMA and specialty societies were not invited to review the Administar coding edits until the eleventh hour. They pointed out a number of problems with the edits and repeatedly requested an implementation delay but HCFA went ahead despite the AMA's concerns. Medicare rules prohibit physicians from balance billing for bundled services and there is no appeal of the denials. Non-par physicians also face limiting charge violations and notice to their patients that their physician billed them incorrectly and owes them a refund. A 2,200-page, $190 manual which explains the coding edits is "not user-friendly", according to one Iowa clinic manager who purchased it. The manual is, in fact, nearly unintelligible. (The IMS has the manual and staff are available to assist member physicians.) The IMS urges physicians to send examples of denials to IMS and their specialty societies. The IMS is passing the denial examples to the AMA for use at the national level. Reportedly, there is particular concern regarding denials for pap smear collection during office visits. For more information about the correct coding initiative, call Barb Cannon of the IMS staff, 515/223-1401 or 800/747-3070. Watch for more on this issue in the April *Iowa Medicine*.

●**ANY PHYSICIAN WHO WANTS TO RESERVE A HOTEL ROOM** at the Embassy Suites for this year's House of Delegates must do so by March 29. A block of rooms for IMS members will be held until that date. The 1996 IMS Annual Meeting and Scientific Session is Friday-Sunday, April 19-21. The telephone number for the Embassy Suites is 515/244-1700 or 800/EMBASSY. The 1996 Scientific Session, which begins Friday, April 19, has been awarded 9 hours CME credit by the AMA and 9 hours by the American Academy of Family Physicians.

●**A RESOLUTION ON SPECIALTY SOCIETY REPRESENTATION** in the IMS House of Delegates will go to the House at the 1996 Annual Meeting April 20-21 at the Embassy Suites. The bylaws change will be considered by the House at its Saturday, April 20 session so that specialty society delegates could be in place for the Sunday, April 21 House session and annual elections. For more information on qualifications and procedures for specialty society delegates, call Sandy Nelson or Dean Gillaspey at the IMS, 515/223-1401 or 800/747-3070.

●**RESULTS ARE IN FROM THE RECENT VOTE** among insureds of Midwest Medical Insurance Company. At issue was whether the company should require insureds in Iowa, Minnesota, Nebraska and North and South Dakota to belong to their state medical societies in order to purchase liability insurance. According to MMIC officials, 65% of policyholders voted in the election; 98% of those voting are in favor of abolishing the state medical society membership requirement. According to MMIC, the decision to put the issue to a vote was made because of marketing realities. The medical society membership requirement was reportedly hurting sales in Minnesota and was used against MMIC by rival companies Medical Protective and St. Paul. As Minnesota's physician groups began to get bigger, medical society membership became a significant factor in insurance purchasing decisions.

For more information about any *DEADLINE* news item, call Chris McMahon at IMS headquarters, 515/223-1401 or 800/747-3070.

Iowa Medicine

MARCH 1996 / VOLUME 86 / 3



About the Cover

William Wickenmeyer, MD, a Des Moines internist, examines a patient. Photo courtesy of Mercy Hospital Medical Center.

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People everywhere are fed up with television and movie violence. An increasing number of studies prove there is a causal relationship between watching violence and being violent.
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The number of FBI agents devoted exclusively to investigating health care fraud has tripled in the past few years. This article offers tips on how to avoid trouble. ● *DAVID GLASER, JD*

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Despite your best efforts, it can happen to any physician. Common sense legal advice that may help you make the best of a bad situation. ● *DAVID GLASER, JD*

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An unending parade of mayhem

For several years I have muttered to myself about the excessive violence on TV and in the cinema. In the past few years there has been an increasing awareness that something must be done about violence in our soeiety.

In *JAMA*, Deeember 8, 1975, Michael Rothenberg attacked and indicted as no mere "entertainment" the unending parade of mayhem to which our children are exposed. The 1976 AMA House of Delegates passed a resolution condemning this violenee.

Pediatricians and family physicians are perhaps more familiar with some of the studies on TV violence. The average American child views 21 to 23 hours of TV per week. By the time today's children reach age 70 they will have spent seven to 10 years of their lives watching TV. Prime time TV has three to five violent acts per hour. Saturday morning children's programming features 20 to 25 violent acts per hour. By the time young people graduate from high school they will have viewed more than 200,000 acts of violence portrayed in various media.

Studies attest to the connection between media violence and aggressive behavior.

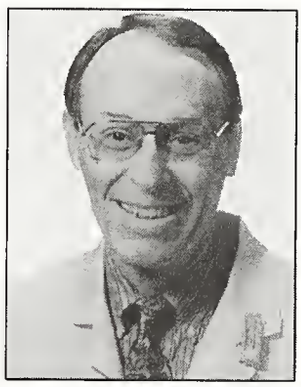
According to a 1992 article in *JAMA*, "through ages three and four years, many children are unable to distinguish fact from fantasy in TV programs and remain unable to do so despite adult coaching. In the minds of these young children TV is a source of entirely factual information regarding how the world works. These earliest and deepest impressions were laid when the child saw TV as a factual source of information about a world outside their home where violence is commonplace and the commission of violence is acceptable. Serious violence is most likely to erupt at moments of severe stress and it is at such moments that adolescents and adults are most likely to revert to their earliest and most visceral sense of what violence is and what the role is in society."

Many studies attest to the causal connection between media violence and aggressive behavior in children. The American Academy of Pediatrics has been an important voice advocating better TV for children. They recommend no more than one to two hours of TV per day.

Parents must understand the importance of limiting viewing of TV violence. The Minnesota Medical Association has published a brochure of 10 tips for parents to stop media violence which is part of their campaign against violence.

Iowa Public Television is sponsoring a seminar for parents regarding television for children. Congress recently passed a new telecommunications bill regarding TV sets containing a "V-Chip" allowing parents to control programs available in their homes.

Clearly, television violence is indeed a contributing factor to violence in our society and we as physicians must work to eliminate this problem. IM



JOSEPH HALL, MD

MANAGED CARE

news you can use

Predicts Medicare will remain a fee-for-service system for now

The Health Care Financing Administration will begin this year to phase in models for a "full range of managed care options", says Kathleen Buto, HCFA's associate administrator for policy. However, Buto predicts Medicare will be primarily a fee-for-service system for the near future, though some reductions in fees could occur if the program to offer managed care options proves workable in rural areas.

US Healthcare Inc. scraps 'gag clauses' in physician contracts

According to a recent article in the *Wall Street Journal,* US Healthcare Inc. has removed provisions from its physician contracts that physicians say hampered their care of patients. The so-called 'gag clauses' are common in managed care contracts. US Healthcare says the language precluded physicians from saying anything that could "undermine the confidence of patients, employers, unions or the public in US Healthcare or the quality of US Healthcare coverage". Physicians say the clauses prevent them from giving patients complete information about treatment options and forbid them from telling patients that HMO financial arrangement may penalize doctors for referrals to specialists. The new language in US Healthcare's contract "encourages" primary care doctors to discuss with patients pertinent details of their condition, including recommended treatments and "reasonable alternatives". It also encourages doctors to discuss the company's reimbursement methodology.

Central Iowa employer coalition expands health benefit program

Representatives of IA Care, a health care benefit program developed by a coalition of central Iowa employers for their employees, say their first year has been successful and that the program is entering its second phase. During the first year, IA Care services were offered through only one health system, the Iowa Health System. As of January 1, the SecureCare Health System and John Deere Health Care System family clinics will also be participating with IA Care. Employees will now have a choice of competing health insurance plans and competing health systems, said Chuck Johnson, president and CEO of Pioneer Hi-Bred International. The employer coalition includes HyVee, Norwest Corporation, Ruan Transportation and other central Iowa employers.

Hospitals don't profit from practice purchases, says survey

A survey of hospital financial officers found that only 17% of hospitals that have purchased physician practices have profited from the purchases, according to a January 5 article in Hospitals and Health Networks. In addition, just 32% of hospital officers reported that the acquisitions met their revenues and expense projections.

Managed care in Iowa



Following is a summary of Iowa's managed care organizations as of January, 1996 and based on information provided by the Iowa Insurance Division. Keep in mind that organizations and alliances change very rapidly in today's evolving health care delivery system.

Organized Delivery System (ODS)

There is one licensed ODS in Iowa — SecureCare of Iowa — which includes physicians, pharmaceutical services and one hospital. It began operation in 1994 and is affiliated with Kirke Van Orsdel. The Iowa Department of Public Health has oversight.

Other states have different names for the ODS type organization (i.e., accountable health plan, integrated delivery system, community network). The ODS contracts with employers to provide benefits; physicians, hospitals and the fiduciary agent bear risk.

Health Maintenance Organizations (HMOs)

HMOs offer prepaid, comprehensive health coverage for both hospital and physician services. HMO enrollees pay a fixed amount monthly for services by providers under contract to the plan. If enrollees go elsewhere for care, they must pay all or a portion of the cost. An outstanding characteristic of HMOs is their ability to drastically reduce utilization and resource consumption. Risk is generally borne by an insurance company.

There are eight HMOs in Iowa and all are licensed by the Iowa Division of Insurance. Three are based in Iowa — Care Choices (Sioux City); Medical Associates Health Plan, Inc. (Dubuque); and Prineipal Health Care of Iowa, Inc. (Des Moines)

Five are based out of state — Exclusive Health Care Inc.; Heritage National Healthplan, Inc.; Principal Health Care of Nebraska, Inc.; John Deere Family Healthplan, Inc.; and United Healthcare of the Midlands, Inc.

Preferred Provider Organizations (PPOs)

A PPO is an arrangement between purchasers of care and providers of care that makes benefits available at a reasonable cost by giving members incentives to use providers within the organization. The PPO's panel of physicians, hospitals and other providers agree to accept a discounted fee schedule for enrollees and to follow utilization review and preauthorization protocols for certain treatments and procedures, including hospitalization. If PPO patients use non-par providers, their deductible and copayments are higher. Risk is borne by an insurer; providers oversight is by the Division of Insurance.

There are 55 PHOs in Iowa. They include Encompass, HealthFirst, Alliance Select, Unity Choice, Healthcare Preferred, Private Health Care System, Inc., Aetna Health Management, CAPP Care, CorVel Corporation, Employee Benefit Systems Corporation and Health Choices PPO.

Health Insurance Purchasing Cooperative (HIPC)

HIPCs shop for low cost, quality health care on behalf of large consumer groups, including small businesses. Because of their size, they have more clout to negotiate better terms and prices for their members.

There is one HIPC in Iowa, the Independent Health Alliance of Iowa. It is regulated by the Division of Insurance. IM

Managed Care in Iowa

- 1 ODS
- 8 HMOs
- 55 PPOs
- 1 HIPC (Health Insurance Purchasing Cooperative)

Note: This article was written by Barb Cannon, director of medical economics for the Iowa Medical Society. For a complete list of Iowa's managed care organizations, contact Ms. Cannon at 515/223-1401 or 800/747-3070.

Managed Care Resources available from IMS

WRITTEN MATERIALS

Conomikes Managed Care Handbook — Conomikes Reports, Inc.
Regulation of Managed Care Organizations: A Legal Perspective — AMA publication
The Managed Care Resource: The Language of Managed Care — United Health Care Corporation
Physician's Managed Care Manual — California Medical Association
Managed Competition: Challenges and Opportunities for Physicians
Sourcebook of State Managed Care Trends and Federation Initiatives — AMA publication
Managed Care and the Market: A Summary of National Trends Affecting Physicians — AMA publication

CASSETTES

Prepaid Health Plans I and II — AMA Doctor's Resource Service
Physician as Gatekeeper — AMA Doctor's Resource Service
Stress Factors in Managed Care — AMA Doctor's Resource Service

VIDEOTAPES

Managed Care: An Overview — AMA Doctor's Resource Service
Physician's Update on Managed Care — AMA Video Journal

The IMS has a comprehensive lending library of managed care materials including articles, booklets and audio and videotapes. Call Sherry, ext. 629 at IMS headquarters, 515/223-1401 or 800/747-3070, for more information.

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Wednesday, March 13	**IMS headquarters, Taylor Room West Des Moines**
Thursday, March 21	**Genesis Medical Center, MOB 2 Conference Room C, Davenport**
Wednesday, March 27	**St. Luke's Regional Medical Center Room 2, Sioux City**
Thursday, April 4	**St. Luke's Hospital, MOP, Room 3, Cedar Rapids**

In today's complex investment and financial environment, and with the ever-changing medical climate, planning for your financial future and adequately managing your investment portfolio can be risky business. The Iowa Medical Society is pleased to continue providing educational opportunities for member physicians and their spouses interested in retirement planning. The upcoming sessions are offered in collaboration with Foster Capital Management, Inc., a West Des Moines company specializing in pre-retirement education.

Jerry Foster is founder and president of Foster Capital Management, Inc. and author of the Retirement Readiness workbook and lecture series. In affiliation with the AMA Investment Advisers, L.P., Jerry frequently speaks for the IMS.

Registration fee is $75 for an individual and $90 per couple. The fee covers a full day program from 10 a.m. until 3:30 p.m., a working lunch, materials and an optional voluntary individual analysis.

★ ICD-9-CM Coding

Thursday, March 21, 1996
9:00 a.m. — 4:00 p.m.
Bettendorf Medical Plaza Conference Center
2535 Maplecrest Road
Bettendorf

This seminar will offer something for coders with all levels of experience. It will cover the basics of the International Classification of Diseases Clinical Modification (ICD•9•CM) coding system. Emphasis will be on using the system effectively and appropriately. Correct use of V-codes will be included. Tips for facilitating insurance claim processing will be discussed.

Note: Bring Volumes 1 & 2 of your ICD•9•CM books.

Instructor: Mary Pat Wohlford-Wessels, MA, MS, RRA, is director of the health care administration program at the University of Osteopathic Medicine and Health Sciences in Des Moines. She holds a master's degree in health care administration and serves on many state committees on data collection.

Registration fee is $99 for IMS members and staff. Registration after March 11 is $119.

★ Resource Management

Wednesday, March 27, 1996
Financial Resource Management — 9:00 a.m. to noon
Human Resource Management — 1:00 to 4:00 p.m.
IMS Headquarters, Taylor Room
West Des Moines

This workshop is designed to provide you with basic information about accounting, tax and human resources issues to assist a successful practice. The workshop will offer a morning session featuring financial aspects of your office that include: basic accounting transactions, reading and understanding financial statements, payroll tax reporting, cost controls and planning for growth.

The afternoon will be dedicated to current human resources issues pertaining to ADA/Family & Medical Leave Act, employee handbooks, changes in insurance regulations, effective employee evaluations/disciplinary procedures and other topics concerning human resources.

Register for the all day program or the AM or PM session only. The AM session will begin at 9:00 a.m. and the PM session will start at 1:00 p.m. The cost of the seminar will be $49/half day or $99/full day. The full day fee includes lunch. Registration after March 17 is $69/half day or $119 for full day.

Presenters: Kathi Koenig, Dave Hansen, Pam Schneider-Jennings and Dan Schwarz from Vroman, McGowen, Hurst, Clark & Smith, P.C. (VMHC&S), a certified public accounting firm.

★These programs are part of the IMS Medical Business Specialists (MBS) Certificate Program.

Registration on reverse side

Registration Form

NAME(S): _____

CLINIC/PRACTICE NAME: _____

ADDRESS: _____

PHONE: _____

FAX: _____

SEMINAR/DATE/LOCATION:

RETIREMENT READINESS _____

ICD•9•CM CODING _____

RESOURCE MANAGEMENT

AM-Financial Resources _____ PM-Human Resources _____ All day _____

AMOUNT ENCLOSED: _____

Please make checks payable to IMS SERVICES

Mail check and registration form to:
IMS SERVICES
ATTN: Sherry Johnson
1001 Grand Avenue
West Des Moines, IA 50265

IMS Update

IMS Annual Meeting April 19-21

The 1996 IMS House of Delegates and Scientific Session will be Friday through Sunday, April 19-21 at the Embassy Suites in Des Moines.

The Seientific Session will feature presentations on Graves' Disease, vascular disease in the elderly and what's new in oncology.

Martin MacNeill, DO, JD of Salem, Utah will be Friday's luncheon speaker. Dr. MacNeill will speak on medieal law and tort reform. The Seientific Session will end Sunday morning with a discussion of teen violence.

(A Scientific Session program with registration information is included with this *Iowa Medicine*.)

The first House of Delegates session will begin Saturday at 8:30 a.m. Any IMS member physician can submit resolutions for consideration by the House.

Election of offieers will take place at the Sunday, April 21 House of Delegates.

IMS delegates should watch their mail for more information about the meeting, resolutions submitted and the slate of candidates.

Alliance meeting format changed

The 1996 IMS Alliance Annual Meeting will be held at the Embassy Suites, 101 E. Locust, Des Moines. A new format for the meeting will be implemented this year. The 1995-96 and 1996-97 IMSA Boards of Directors will meet Thursday, April 18. The formal opening of the 67th House of Delegates will be at 9:00 a.m., Friday, April 19.

Carol Phillips, AMAA field director from Marshfield, Wisconsin will be our special guest. All physician spouses are welcome to attend any or all of the IMSA Annual Meeting.

Family Practice Opportunities Fair

The 1996 Family Practice Opportunities Fair will be August 24, 1996 at the Savery Hotel and Des Moines Convention Center. The fair is sponsored by the Iowa Family Practice Residents Council, the University of Iowa College of Medicine, the Iowa Academy of Family Physicians and the Iowa Medical Society.

Registration information will be mailed in June, or call 319/335-8616. IM

Specialty Society Update

The Iowa Medical Group Management Association Spring Meeting will be May 22-24 at the Des Moines Marriott. The theme of the meeting will be "Staying Up in an Upside Down World". Keynote speaker will be Jacque Sokolov, MD. Dr. Sokolov will discuss integrated delivery systems and optimal physician organizations.

The Iowa Psychiatric Society issued its first 1996 newsletter, edited by Loren Olson, MD. The IPS Legislative Committee has reinstituted its weekly telephone conference calls to discuss pending legislation.

The American Medical Directors Association, Iowa Chapter is planing its Spring Meeting and has received financial support from Bristol-Myers Squibb and the Connections Program at Des Moines General. Approximately 500 people plan to attend this conference at the Iowa State Center, Ames.

The American College of Cardiology, Iowa Chapter, is planning a reception during the annual meeting of the ACC March 24. Philip Habak, MD, Davenport, new ACC-Iowa Chapter president, will be honored.

Organ procurement and pending state legislation on cremation permits were on the agenda at a recent meeting of the Iowa Association of County Medical Examiners Board of Directors.

The Iowa Society of Anesthesiologists is planning its Annual Anesthesia Update for Saturday, April 13 at the Mariott Hotel in Des Moines.

AT A GLANCE

Iowa COMPASS, an information and referral service for Iowans with disabilities, is looking for individuals to serve on its advisory board. All terms are for three years and the group meets twice annually. For more information, call 800/779-2001.

The Association of Iowa Hospitals and Health Systems (IH & HS) Annual Meeting will be Monday-Thursday, April 22-25 at the Marriott Hotel. Health care leaders will focus on the theme "Acting on a Vision". For more information, call 515/288-1955.

March 29 is the deadline for IMS member physicians who wish to reserve a room from the IMS block of rooms at the Embassy Suites for the 1996 House of Delegates and Scientific Session. Call 515/244-1700 or 800/EMBASSY for reservations.

THROCKMORTON SURGICAL SOCIETY
and
IOWA ACADEMY OF SURGERY
ANNUAL SPRING MEETING

SURGICAL SYMPOSIUM ON LAPAROSCOPIC PROCEDURES

APRIL 19-20, 1996

Iowa Methodist Medical Center - Jester Auditorium
Des Moines, Iowa

W. Peter Geis, M.D.
Director, Minimally Invasive Surgical Training Institute
St. Joseph Medical Center
Associate Professor, St. Joseph Hospital
Baltimore, Maryland

Ronald A. Hinder, M.D., Ph.D., F.A.C.S.
Professor, Surgery - Creighton University
Omaha, Nebraska

Carol Scott-Connor, M.D., Ph.D.
Chairperson, Department of Surgery
The University of Iowa College of Medicine
Iowa City, Iowa

Adel S. Al-Jurf, M.D.
Professor, Department of Surgery
The University of Iowa College of Medicine
Iowa City, Iowa

Robert L. Kollmorgen, M.D.
General Surgeon
Des Moines, Iowa
Clinical Assistant Professor, Surgery
The University of Iowa College of Medicine

Joseph B. Petelin, M.D.
Assistant Clinical Professor, University of Kansas
Shawnee Mission, Kansas

Gerald J. Shirk, M.D.
Gynecologic Surgeon, OB Gyn Associates, P.C.
Cedar Rapids, Iowa

Steven Allgood, M.D.
General Surgeon
Mason City Clinic
Mason City, Iowa

Pablo Recinos, M.D.
General Surgeon
Mason City Clinic
Mason City, Iowa

TOPICS

"Status of Laparoscopic Colon/Rectal Surgery"
"Laparoscopic Anti-reflux Procedure"
"Laparoscopic Common Bile Duct Exploration"
"Laparoscopic Splenectomy and Adrenalectomy"
"Cost Containment in Laparoscopic Surgery"
"Laparoscopic Evaluation & Treatment of Adnexal Masses"
"Laparoscopic Herniorrhaphy"
"Laparoscopic Treatment of Peptic Ulcer Disease"
"Laparoscopic Pelvic Reconstruction"
"Diagnostic Laparoscopy: Uses and Pitfalls"
"Pyloric Preservation with Whipple Procedure"
"Resection vs. Bypass"
"What's Here and Now? What Does the Future Hold for Laparoscopic Surgery?"
"Evolution of the Surgical Approach to Pancreatic Neoplasms"
"Pancreatoduodenectomy: Comparing the Total Whipple Procedure vs. Total Pancreatectomy"

ACCREDITATION

As an organization accredited by the Iowa Medical Society for continuing medical education, Iowa Methodist Medical Center certifieds that this continuing medical education offering meets the criteria for Category I credit toward AMA Physician's Recognition Award, provided it is used and completed as designed.

April 19: 7 hours
April 20: 3 hours

COST

Physician Fee $150.00
Resident Fee $35.00

CONTACT

Surgery Education Office, Iowa Methodist Medical Center
1221 Pleasant Street, Des Moines, IA 50309 Phone: (515) 241-4076

Legislative Affairs

Physician contacts make a difference

As of press time, physician contacts with legislators were making a difference with legislators on the group B strep bill (HF 2182).

This bill, which is opposed by the Iowa Medical Society, would require all physicians who provide prenatal care to perform screening cultures for group B strep between the 35th and 37th weeks of pregnancy.

HF 2182 would also require the physician to inform the patient of the test results, risks, diagnosis, prevention and treatment. The Department of Public Health would be directed to adopt rules to implement the legislature's protocols.

IMS legislative contact physicians were asked to call their lawmakers and raise concerns about this bill. There is one obvious problem with the bill which has been pointed out by IMS legislative representatives — there are at least five different protocols from reputable national medical organizations addressing group B strep.

Due to contacts by physicians, lawmakers were beginning to understand the problems inherent in the bill. However, as of press time, the bill had been put on the "fast track" and was approved by the Human Resources Committee February 15.

If you haven't already done so, please discuss this issue with your state representative. Voice your opposition to HF 2182 and help educate legislators on this issue. Make these points:

•This is a complex issue and there is no consensus on the best mode of testing or treating. Nationally recommended protocols change regularly. There is no single "right" way.

•Choosing one protocol to put in the law means that Iowa patients will not benefit from new research and recommendations as soon as they become available.

Other issues heating up at the Statehouse

PA/NP reimbursement — HF 2144

On Monday, February 19, the House approved HF 2144 on a vote of 87 to 8. HF 2144 provides that a third party payer must pay for services of a physician assistant or nurse practitioner if the payer would pay for the same services of a physician.

The IMS opposes this bill. IMS has a long-standing policy in opposition to mandates. Even without this bill, most third party payers will pay for PA or NP services as long as the services are billed through the supervising or collaborating physician.

State insurance mandates apply only to a small portion of health care benefit plans because self-insured employer plans are regulated by the federal government. Mandates can result in more large employers going to self-insured plans and small employers dropping employee health insurance. At press time, this bill was scheduled to go to the Senate for consideration.

Direct access to chiropractors — HSB 544

HSB 544, scheduled to be discussed by the House Human Resources Committee Feb-

continued

Contacting Your Legislators

Telephone numbers during the session:

Senators	**515/281-3371**
Representatives	**515/281-3221**
Governor	**515/281-5211**

Write to them at:

STATEHOUSE
Des Moines, Iowa 50319

You may contact your legislators at home when the Iowa Legislature is not in session. If you don't know your legislator's home address and phone number, call Cheryl Peers of the IMS staff, 515/223-1401 or 800/747-3070.

AT A GLANCE

State public health officials are warning Congress that program cutbacks are likely without a resolution of the federal budget stalemate. Congress funded NIH, CDC, FDA and Medicaid for the year, but many other service, prevention, research and training projects got temporary funds that expire March 15.

In a press release, the AMA applauded the attention paid to public health issues in President Clinton's state of the union address. The AMA specifically mentioned anti-tobacco efforts, the anti-violence television v-chip and domestic violence.

Legislative Affairs

continued

ruary 20, would prevent a managed care plan from using a physician gatekeeper for chiropractic services. The bill also would prevent primary care MDs from serving as gatekeepers for DO specialists and primary care DOs from serving as gatekeepers for MD specialists. The IMS strongly opposes this bill.

Other issues

Maternity care coverage is being discussed but no bills had been approved as of press time. SF 348 which defines surgery appears stuck in committee in the Senate. Two tobacco regulation bills (SF 2174 and 2078) have been approved by the Senate Human Resources Committee.

The first funnel deadline was March 1 when most bills must have been approved by a committee to be eligible for further consideration. Tax and appropriations bills are exempt.

SF 2066 setting specific penalties for assisted suicide has passed the Senate and is expected to be considered by the House. The IMS supports the bill in its present form; it is consistent with the AMA's ethical position on assisted suicide. The IMS worked on the language of the bill to ensure that it did not interfere with the practice of physicians who are managing the pain of dying patients and that withdrawal of life sustaining care is not considered assisted suicide.

SF 258, the bill directing the Department of Public Health to set allowable charges for copies of medical records provided to attorneys, has not been acted on by the House Judiciary Committee. The IMS has been lobbying hard against this bill. The IMS believes that the government should not regulate fees within the private sector. Physician offices are encouraged to refer to the "Principles of Cooperation for Attorneys and Physicians" developed by the IMS and the Iowa State Bar Association for guidance in developing a charge for copies of medical records.

SF 2167, which would increase penalties for assaults on emergency workers in hospitals, has been approved by the Senate Judiciary Committee. This bill is an initiative of emergency physicians and is intended as a deterrent to the increasing number of assaults in emergency rooms.

For more information

For more information about issues, call Becky Roorda of the IMS staff at 515/223-1401 or 800/747-3070. IM

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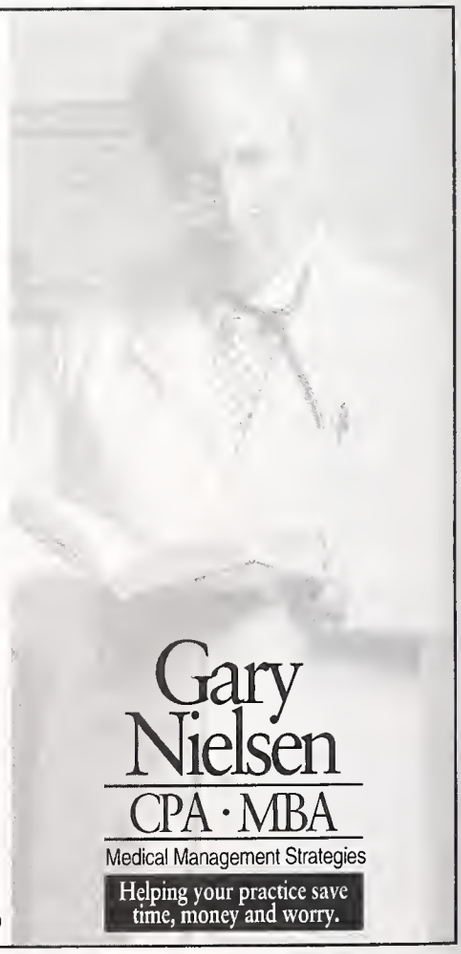
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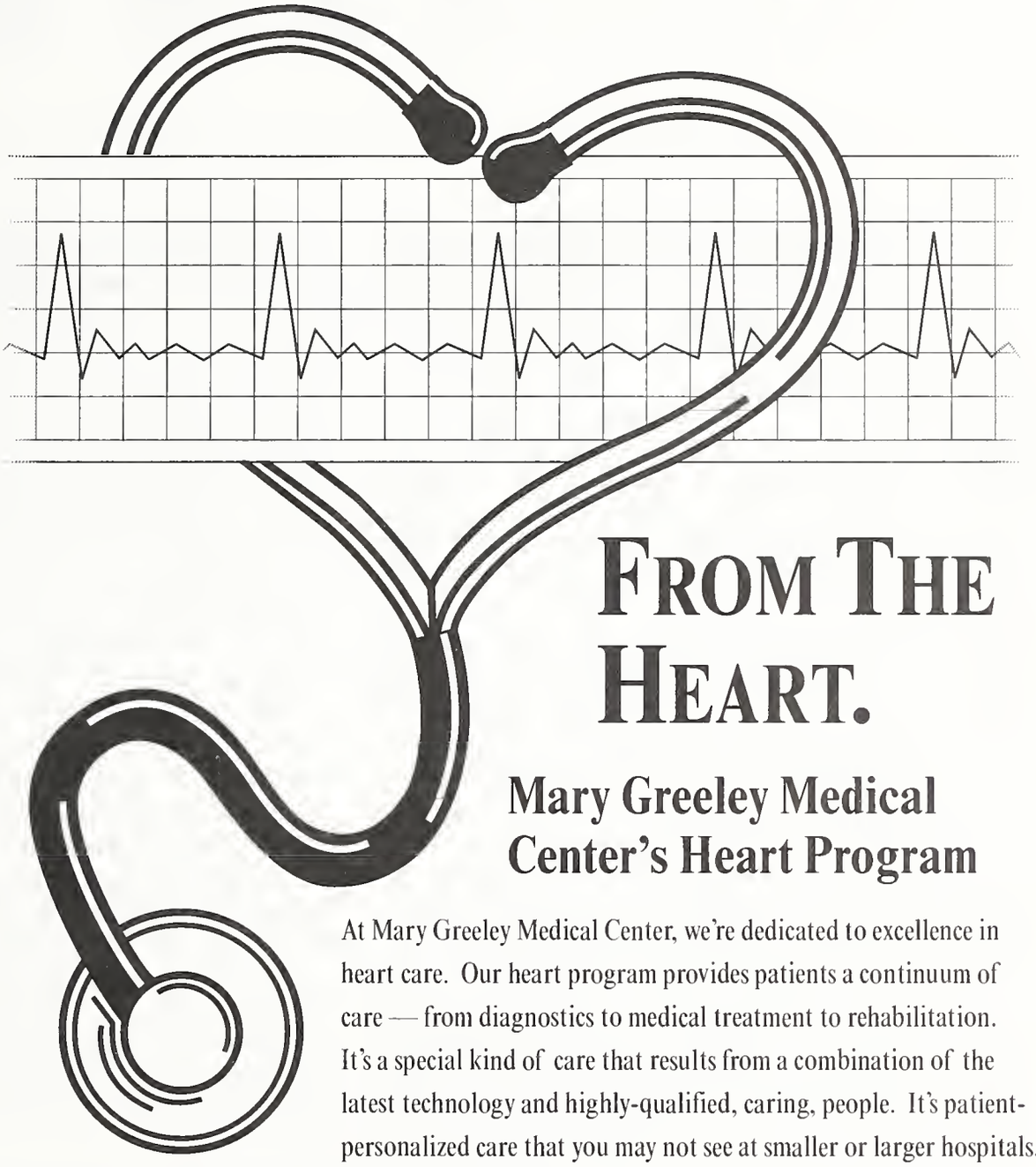
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Medical Economics

Study could revamp Medicare pay system

A government study which could lead to an overhaul of the Medicare payment system is officially underway.

Late last month, surveys of practice costs were mailed to 5,000 physicians across the U.S. The survey is one component of a larger study which will be the basis for an overhaul of the Medicare RBRVS. (At press time, it was not known whether any Iowa physicians received a survey.)

Substantial payment swings could result from the study; since the RBRVS is also used by many private payers, the study's implications could reach far beyond Medicare.

According to a recent issue of *AM News*, the AMA and national medical specialties are urging members to complete the survey, despite some anxiety about the study. Since the law mandating the study is in place, most specialties agree that the changes should be based on credible data.

However, due to concerns over the study's sample size, questions and time frame, some national physician groups have hired their own consultants to conduct parallel studies. National specialty groups voicing concern include the Academy of Family Physicians, the American College of Surgeons, the American College of Emergency Physicians, the American College of Cardiology and the Medical Group Management Association. These groups voiced their concerns at a PPRC hearing in December.

The practice cost study was mandated by Congress in 1994 to compare relative practice costs of various services and use the comparisons to recalculate the practice expense portion of the RBRVS. Proposed changes in the relative values are expected to be published in early 1997 and implemented by January 1, 1998.

Watch future issues of *Iowa Medicine* and *AM News* for updates on the progress of this important study.

AT A GLANCE

The number of Iowa Medicare beneficiaries who received flu shots decreased by nearly 5% in 1994, according to the Iowa Part B *newsletter. In 1994, 190,067 beneficiaries received shots compared with 198,792 in 1993.*

A recent study suggests that more than $1 billion could be saved annually by testing breast lumps with needles instead of the usual surgical biopsies. In the study, the average hospital bill for women who had needle biopsies at a hospital was $1,484; the average bill for those who opted for surgical biopsies was $4,625.

One number for one provider

HCFA, state Medicaid and other federal agencies have launched an initiative to develop a National Provider System and assign a unique National Provider Identifier (NPI) to health care providers. The object is to standardize and simplify provider enumeration.

HCFA says providers will benefit from the advent of the NPI. Once a provider receives an NPI number, the provider will keep that number throughout his or her career. Even providers who change specialties, expand to other locations or re-enter practice will keep the same number.

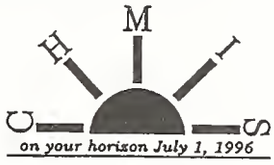
For Medicare, the NPI will serve as a provider identification number and a billing number. The number will be used on all correspondence, bills and claim forms. In addition, providers may use the same NPI number to submit claims to different carriers, intermediaries and DME regional carriers.

HCFA will begin issuing the eight-digit National Provider Identifiers to Medicare providers this summer. It is anticipated providers will be required to use their NPI on Medicare claims beginning in January of 1997.

HCFA policy on ordering x-rays

IMS staff has been receiving calls from radiologists regarding Medicare policy on ordering x-rays. Medicare policy requires that x-rays used to demonstrate the need for chiropractic services must be ordered by an MD or DO, according to a recent statement from HCFA.

Radiologists are sometimes contacted to order x-rays. Although this is allowable under HCFA policy, liability carriers say radiologists who do so may expose themselves to liability risks. IM



CHMIS Update

What is the future of CHMIS?

The Iowa CHMIS will have a significantly altered look if new recommendations from a special task force are approved by the Governing Board.

Based on extensive discussions during January and February, the task force is recommending that the centralized data repository be abandoned and that providers not be required to submit insurance claims electronically.

Though repeal of the CHMIS law is unlikely, the task force, the IMS CHMIS Committee and others agree the centralized data repository would add to the cost of health care administration rather than reduce costs.

However, the task force believes development of electronic standards for a variety of transactions (insurance claim submission, eligibility verification, remittance advice, claims status inquiry and supplemental information) should continue.

As you read in last month's *Iowa Medicine*, the CHMIS process encountered a significant road block when bids to operate the centralized data repository came in much higher than expected. This resulted in two actions by the CHMIS Governing Board: 1) A recommendation was made to the Iowa Legislature that implementation of CHMIS be delayed to July 1, 1997; and 2) A special task force was appointed to develop options for the future of CHMIS. Dale Andringa, MD, a Des Moines physician and member of the CHMIS Governing Board, and Eldon Huston, IMS executive vice president, served on this task force. Other members represented hospitals, payers, business and consumers.

The task force recommendations are consistent with those developed by the IMS CHMIS Committee January 11. Since the inception of CHMIS, the IMS has supported electronic claims submission while opposing a centralized data repository. The physician opposition was mainly due to patient confidentiality concerns.

The CHMIS Governing Board will now seek access to proprietary data bases such as those of insurance companies in order to generate public interest reports.

For more information about CHMIS developments, call Ed Whitver of the IMS staff, 515/223-1401 or 800/747-3070. IM

Key CHMIS task force recommendations

1. A centralized data repository will not be created. However, work on establishing electronic data interchange standards will continue.

2. Physicians will not be required to contract with a network or to send insurance claims electronically. The Governing Board will encourage the increased use of electronic transactions.

3. Networks will not be certified; a market driven, buyer beware environment will exist.

4. The 12-member CHMIS Governing Board structure will remain in place, with oversight by the Insurance Division.

5. The five CHMIS Advisory Committees will be replaced by three advisory committees on Standards, Data Analysis and Reporting and Ethics and Confidentiality. (Physicians interested in serving on these committees may contact Ed Whitver of the IMS staff.)

The Governing Board was to review the task force recommendations February 16. IMS staff expected they would be approved without significant changes. At press time, the Iowa Legislature had not acted upon the recommendation to delay implementation of CHMIS. If the legislature supports the change, the Iowa Health Data Commission will be dissolved on July 1, 1996 as scheduled in the original CHMIS law.

YOUR representatives on state CHMIS committees:

CHMIS Governing Board:

Dale Andringa, MD
Des Moines
515/241-4102

Beth Bruening, MD
Sioux City
712/233-1529

CHMIS advisory committees:

Communications/ Education
Laine Dvorak, MD
Clarence Denser, Jr., MD

Data Advisory
John Brinkman, MD

Ethics/Confidentiality
Charles Jons, MD

Quality Review
Elie Saikaly, MD
William Langley, MD

Technical Advisory
Mark Purtle, MD

IMS CHMIS Committee:

Terrence Briggs, MD (chair)

IMS staff:
Barb Cannon
Ed Whitver
Dean Gillaspey

Practice Management

HCFA audit worksheet clarification

Anyone who attended the IMS workshop "Using HCFA's E & M Code Documentation Guidelines and Audit Score Sheet" is cautioned on correct use of the MGMA score sheet in Section 2 — the physical exam key component.

Physical exam guidelines beyond the "problem-focused exam" give recognition only to **organ systems**, not body areas. The instructions on the worksheet are clear on this issue; however, a common error is to combine the total body areas and organ systems. This is not the correct application.

For more information, contact Barb Cannon of the IMS staff, 515/223-1401 or 800/747-3070.

1996 CPT code change

Please note that CPT codes 99401-404 "Preventive Medicine, Individual Counseling" have been modified. According to the notes preceding the codes in the 1996 book, these are to be used to report services "at a **separate encounter** for the purpose of promoting health and preventing illness or injury". Previously, these were "add-on" codes reported with preventive medicine services.

Upcoming IMS Services seminars

Coping with basic accounting, tax and human resources issues in your practice will be the subject of the seminar "Resource

AT A GLANCE

Thinking about retirement? IMS Services is offering a series of seminars on retirement readiness at four locations in Iowa this month. The seminar is open to IMS member physicians and spouses and is taught by Foster Capital Management, a West Des Moines company specializing in pre-retirement education. The seminar will be presented in West Des Moines, Davenport, Sioux City and Cedar Rapids. For details, check the insert to this month's Iowa Medicine.

All physicians involved in Medicaid's managed care mental health access plan (MHAP) can now submit claims electronically to MBC of Iowa. For more information, contact Wade Beadwell at MBC, 800/866-5636, ext. 3257.

Midwest Medical Insurance Company Focus on Risk Management

Allied health professionals

A 50-year-old man was examined by a physician assistant (PA) for rectal bleeding. The PA diagnosed hemorrhoids and did not recommend follow-up. Subsequent visits with the same complaints led to the same diagnosis by the PA. The patient was never referred to the physician. Months later, he was hospitalized with a large rectal tumor. The malpractice claim alleged that the physician failed to supervise and monitor care provided by the PA.

Allied health professionals can save time for the physician while providing quality care; but, as this case illustrates, you could have potential liability exposure when registered nurses, nurse practitioners, physician assistants and others are employed by the physician.

In medical malpractice law, an employer is responsible for the negligence of an employee operating within the scope of employment. If you employ an allied health professional and that person injures a patient, you may be liable for any negligence. The physician's duty to supervise the allied health professional may require working as a collaborative team to minimize the risks of patient injury.

Reduce your liability risk when employing an allied health professional by:

- Know and follow the state laws on licensure, scope of practice and supervision of your allied health professional.
- Clearly identify allied health professionals to patients.
- Implement an ongoing process for reviewing the care provided by allied health professionals. Establish collaborative team efforts in discussing patient cases.
- Institute a policy that specifies the role of all allied health professionals in caring for patients and outlines appropriate referral to the physician.

For further information, contact Lori Atkinson, MMIC risk management supervisor, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.

Management" Wednesday, March 27 at IMS headquarters in West Des Moines.

The seminar is open to all IMS member physicians and their staff and is part of the Society's MBS certificate program.

The seminar, taught by members of a Des Moines CPA firm, is divided into morning and afternoon sessions. The morning session will cover accounting transactions, understanding financial statements and payroll tax reporting. The afternoon session will be dedicated to changes in insurance regulations for employees, effective employee evaluations and other human resource issues.

You may register for either the morning or afternoon session, or for both sessions. For more information and a registration form for this and other seminars being offered through IMS Services this month, see the special insert in this month's *Iowa Medicine* or call Sherry Johnson at IMS Services, 515/223-2816 or 800/728-5398. IM

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2024 South 6th Street, Brainerd, Minnesota 56401

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Newsmakers

AT A GLANCE

The January IMS Executive Council meeting was cancelled due to inclement weather. This would have been the last Council meeting for Dr. James White, immediate past president and Dr. Albert Coates, District 3 councilor, who has decided not to seek reelection. Sincere appreciation is extended to Dr. White for his many years of dedicated service to the IMS and the medical profession. Thanks also to Dr. Coates for his excellent service to organized medicine.

Awards, appointments, etc.

Dr. Charles Clark, UI College of Medicine professor of orthopaedic surgery, has been elected to the board of directors of the American Academy of Orthopaedic Surgeons. **Dr. Robert Kelch**, dean of the UI College of Medicine, has been appointed to the Association of American Medical Colleges Advisory Panel on Biomedical Research. **Dr. Sohan Singh Hayreh**, UI professor of ophthalmology, received the Duke-Elder Medal, the highest honor given by the Royal College of Ophthalmologists in Great Britain. **Dr. Bradley Britigan**, UI professor of internal medicine, has been named president-elect of the American Federation for Clinical Research.

New members

Indianola
James Bice, DO, family practice

Iowa Falls
Barbara Bell, DO, family practice
Harsha Jayawardena, MD, family practice
Rebecca Jenkins, DO, family practice
Thoo Huat Tan, DO, obstetrics/gynecology

Knoxville
Javaid Abbasi, MD, DO, internal medicine
Timothy Arnott, MD, family practice

Manning
Barbara Hodne, DO, family practice

Mason City
Robert Fagerholm, MD, resident
Laura Ferguson, MD, resident
Daniel MacAlpine, MD, resident
Timothy McKone, MD, general surgery
Mark Nielsen, MD, cardiothoracic surgery
Anil Poulose, MD, cardiology/internal medicine
Steve Scurr, DO, resident
Michael Sparacino, DO, family practice
Douglas Timboe, MD, resident
Lance VanGundy, MD, resident

Oskaloosa
Fawad Zafar, MD, general surgery

Pella
Russell Bandstra, MD, urology

Sioux City
Jay Allison, MD, resident
Susan Caldwell, MD, pediatrics
Vijay Chawla, MD, pediatrics
Nestor Dans, MD, cardiovascular surgery
Stephen Dick, MD, radiation oncology
Patrick Ducy, MD, family practice
Kristine Everding, MD, resident
Gregory Halbur, MD, family practice
Andrea Herman, MD, resident
Sheila Holcomb, MD, resident
Scott Lichty, MD, resident
Joseph Liewer, MD, emergency medicine
Yunus Moosa, MD, cardiology
Noreen O'Shea, DO, family practice
Gordon Porter, MD, orthopaedic surgery
Danielle Prince, MD, resident
Kurt Rosenkrans, MD, family practice
Caridad Tan, MD, nephrology/internal medicine

South Sioux City
Said Sana, MD, family practice

Spencer
Ma Chris, DO, psychiatry/child psychiatry
Joseph Hart, MD, otolaryngology

Waterloo
Steven Carp, MD, plastic surgery/general surgery
Paul McCaughey, DO, family practice
Barbara Oolman, MD, family practice

Deceased member

Edward Encboe, MD, 79, life member, family practice, Mesa, Arizona, died October 6 IM

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Director, Sleep Disorders Laboratory
Alexian Brothers Medical Center
Elk Grove Village, Illinois

Katherine Elsner, D.D.S..... **"Alternative Treatments for Sleep Apnea: Dental Devices"**
Private Practice of Dentistry
Des Moines, Iowa

Donald Burrows, M.D..... **"Economic Impact of Sleep Disorders"**
Director, Mercy Sleep Center
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500 FBI AGENTS

(coming to a practice near you)

Five hundred agents of the Federal Bureau of Investigation are helping the government collect money from people just like you. Here are some tips for avoiding trouble.

The number of FBI agents devoted exclusively to examining health care fraud has tripled in the last three years. Agents who had been following suspected Soviet agents are now attempting to detect billing fraud. Moreover, Medicare and Medicaid have increased the number of audits to detect improper coding.

What, me worry?

A Medicare audit can be a very unpleasant experience, even for physicians who believe they are coding and billing appropriately. Medicare has many complex rules which often appear to be irrational. On some occasions, Medicare will use one of these rules to recoup money even when you have provided competent, medically necessary services. Unless there is clear evidence in the medical record justifying the code used for a service, Medicare auditors may conclude that there has been an overpayment.

The government has very potent weapons to address any billing or documentation problem. First, a provider may face criminal penalties for any willful disregard of the Medicare/Medicaid billing rules. While criminal penalties are certainly troubling, the government's ability to seek civil penalties is equally troubling and perhaps more surprising.

Criminal penalties apply only if you consciously attempt to defraud the program; civil penalties may apply to some billing errors, including insufficient documentation.

For example, consider a physician who systematically codes exams as 99213 outpatient visits which require about 15 minutes of contact and an expanded problem-focused history or expanded problem-focused exam. If Medicare believes the documentation supports a more routine problem-focused history or exam, penalties of $5,000 to $10,000 per claim may be levied in addition to a fine of three times the size of the improper payments.

Watch for signs

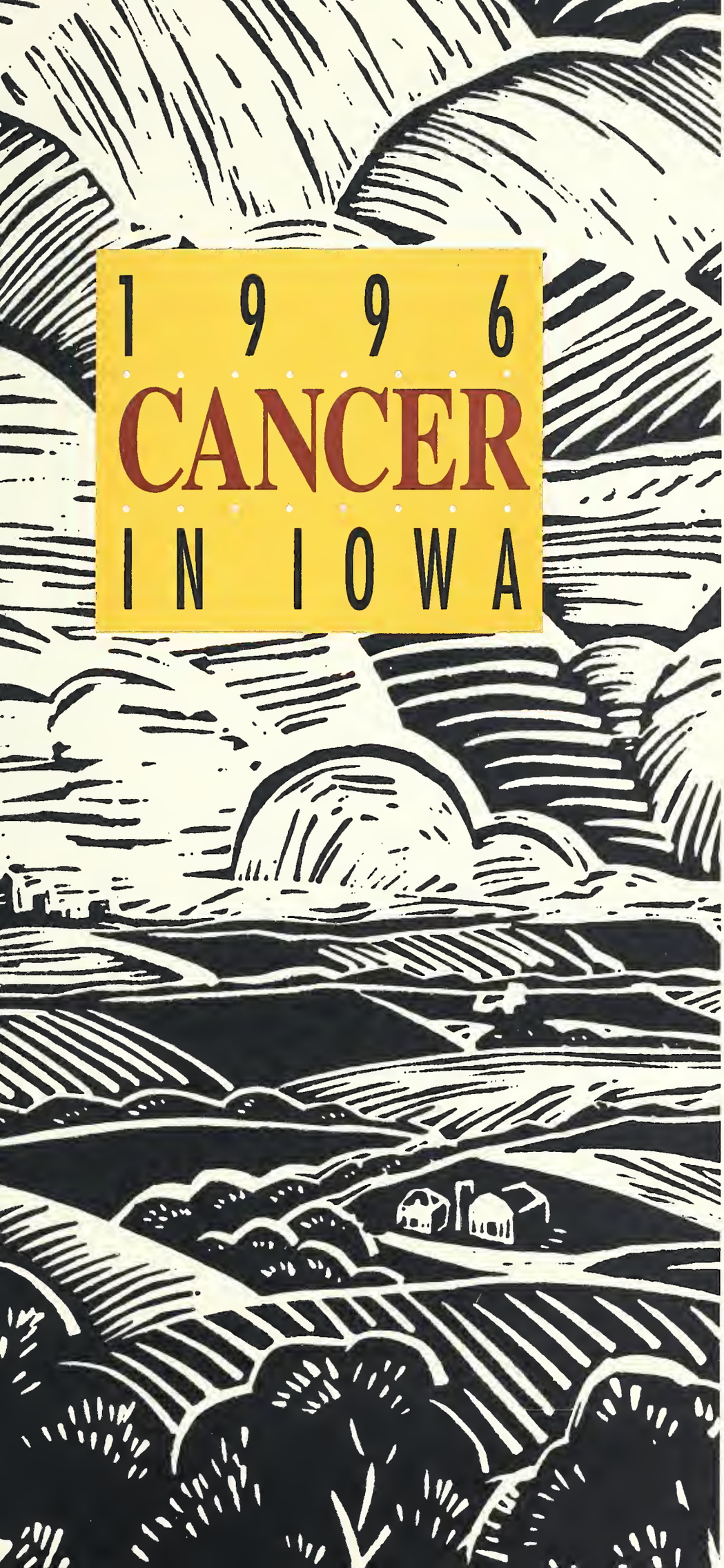
There are warning signs which could alert physicians who may become the objects of major Medicare investigations. Consider any overpayment letter to be a "shot across the bow." Many letters will seek a very small reeovery involving only a few thousand dollars or less. The amounts are small enough that you may be

There are warning signs to alert physicians who may become the objects of major investigations.



DAVID GLASER, JD
Mr.Glaser is a member of his firm's health law group and a founder of its health audit and investigation group. His practice focuses on health care regulation and compliance.

The author practices with the firm of:
Fredrikson & Byron
900 Second Avenue South
Minneapolis, MN 55402
612/347-7000



FACTS ABOUT CANCER IN IOWA

Heart disease is the leading cause of death, followed by cancer.

Education and screening programs can help detect cancer sooner.

Attitudes and lifestyle factors greatly influence one's risk of cancer.

Lung cancer is the leading cause of cancer deaths in both males and females.

Thirty percent of new cancers in females are breast cancers and twenty-eight percent of new cancers in males are prostate cancers.

Higher survival rates have been seen in males and females diagnosed with cancer in 1983-1987 compared to 1973-1977.

In 1996, an estimated 6,700 Iowans will die from cancer, 13 times the number caused by auto fatalities. Cancer is second only to heart disease as a cause of death. The percentage difference between heart disease and cancer is narrowing. The State Health Registry of Iowa has been recording the occurrence of cancer in Iowa since 1973, and is one of ten registries nationwide providing data to the National Cancer Institute.

Produced by
STATE HEALTH REGISTRY OF IOWA
The University of Iowa, 100 Westlawn S
Iowa City, IA 52242-1100
319-335-8609

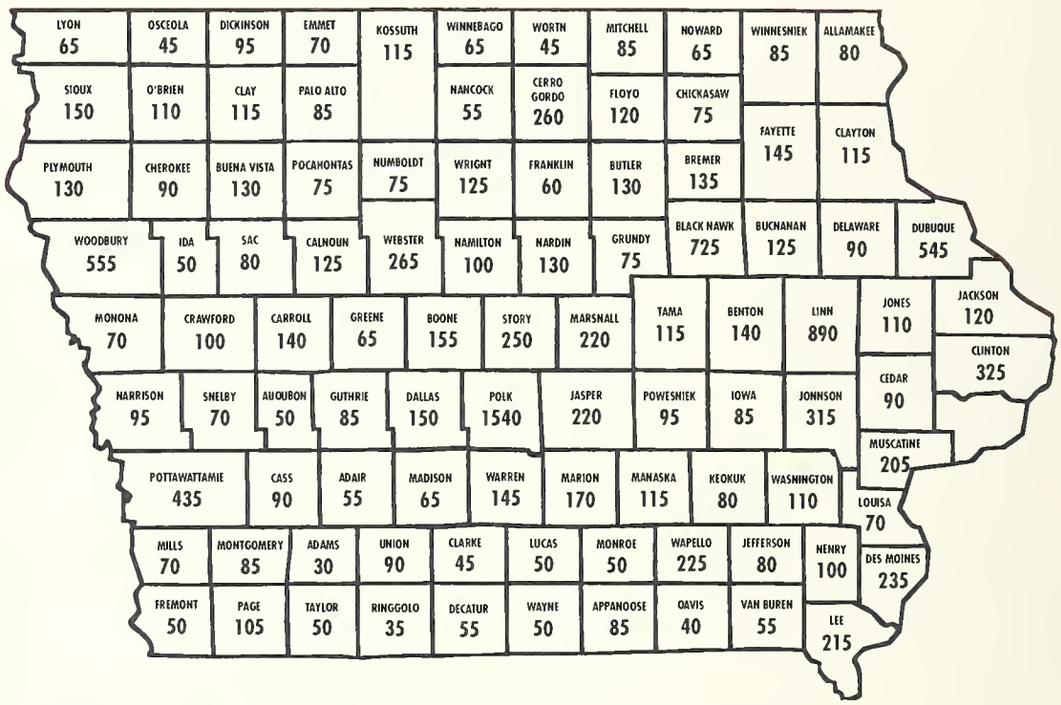
Cancer data are collected by the State Health Registry of Iowa, located at The University of Iowa in the College of Medicine's Department of Preventive Medicine and Environmental Health. The staff includes more than 50 people. Half of them, situated throughout the state, regularly visit hospitals, clinics, and medical laboratories in Iowa and neighboring states. In 1996, data will be collected on 15,400 new cancers among Iowa residents. A follow-up program tracks more than 97 percent of the 280,000 Iowans diagnosed with cancer since 1973. This program provides regular updates to keep the data current and useful. The registry maintains the confidentiality of the patients, physicians, and hospitals providing data.

This excerpt provides information from the State Health Registry's annual publication *1996 Cancer in Iowa*.

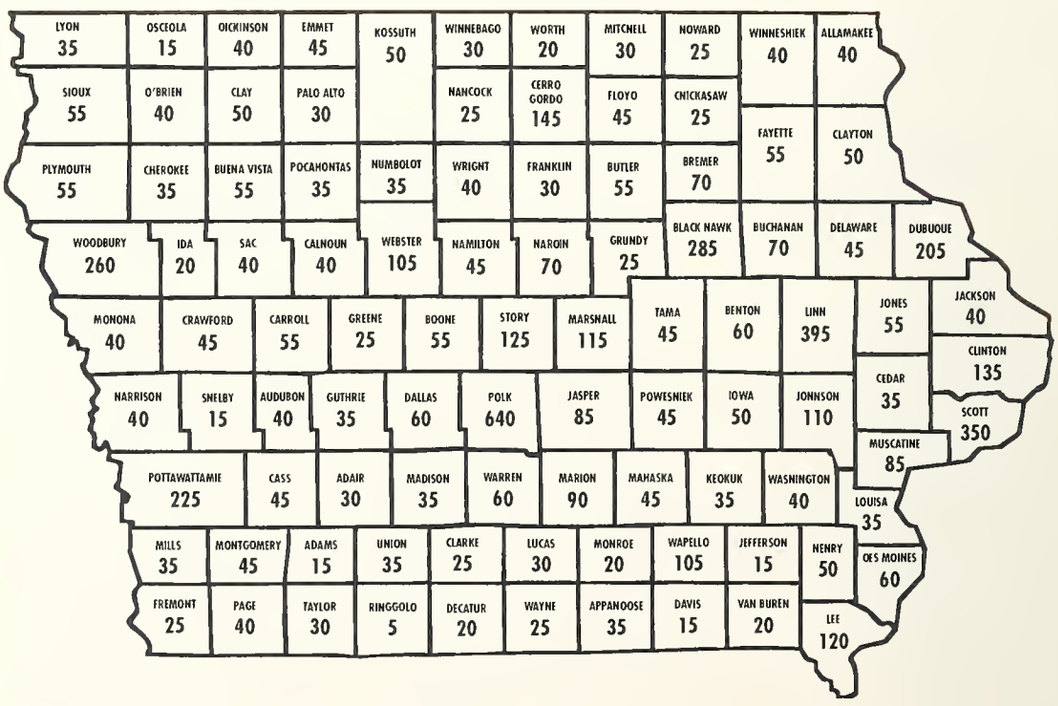
CANCER PROJECTIONS FOR 1996

Cancer affects Iowans of all ages and in every county. In 1996, cancer will strike five out of every 1,000 and bring death to two of them.

ESTIMATED NUMBER OF NEW CANCERS IN IOWA FOR 1996



ESTIMATED NUMBER OF CANCER DEATHS IN IOWA FOR 1996



Breast cancer is the most common female cancer and, along with colon, rectum, and lung cancers, will account for more than half of all new cancers. Lung cancer is the most common cause of cancer death in females followed by breast cancer.

TOP 10 TYPES OF CANCER IN IOWA ESTIMATED FOR 1996

New Cancers in Females

TYPE	# OF CANCERS	% OF TOTAL
BREAST	2200	30.1
COLON & RECTUM	1100	15.1
LUNG	790	10.8
UTERUS	450	6.2
NON-HODGKIN'S LYMPH.	325	4.5
OVARY	290	4.0
LEUKEMIA	210	2.9
SKIN MELANOMA	200	2.7
PANCREAS	185	2.5
KIDNEY & RENAL PELVIS	160	2.2
ALL OTHERS	1390	19.0
TOTAL	7300	

Cancer Deaths in Females

TYPE	# OF CANCERS	% OF TOTAL
LUNG	650	20.3
BREAST	520	16.3
COLON & RECTUM	400	12.5
OVARY	165	5.2
NON-HODGKIN'S LYMPH.	155	4.8
PANCREAS	150	4.7
LEUKEMIA	125	3.9
UTERUS	80	2.5
BRAIN	80	2.5
KIDNEY & RENAL PELVIS	65	2.0
ALL OTHERS	810	25.3
TOTAL	3200	

Prostate, lung, colon, and rectum cancers account for almost 60 percent of all new cancers in males. Lung cancer causes almost one-third of all male cancer deaths.

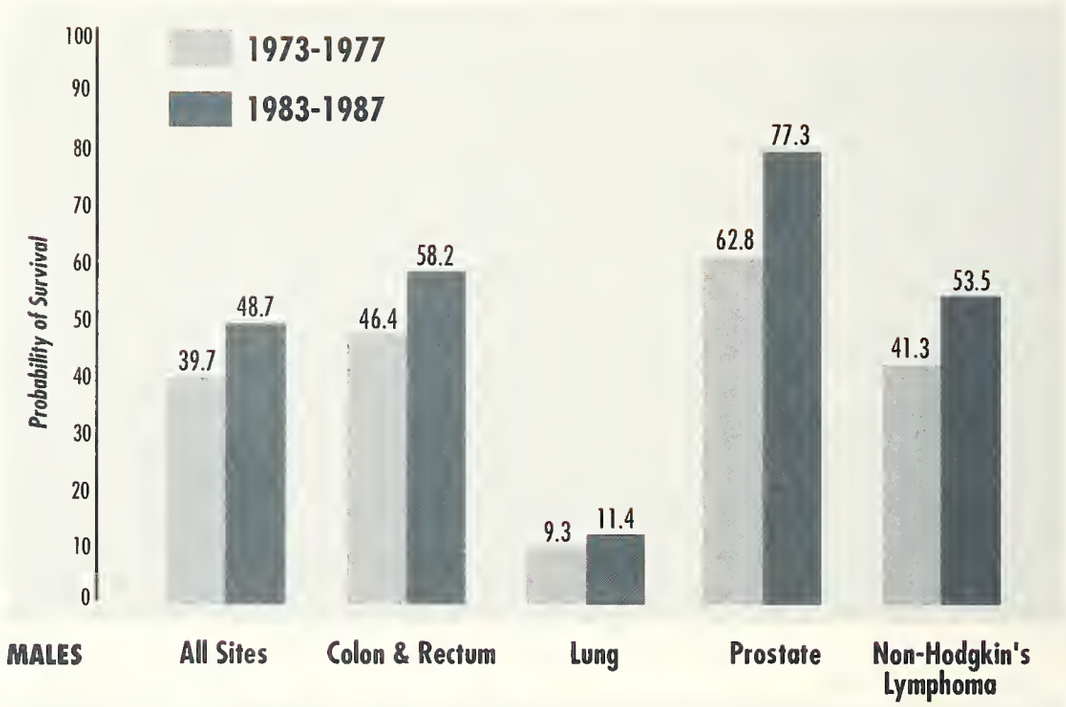
New Cancers in Males

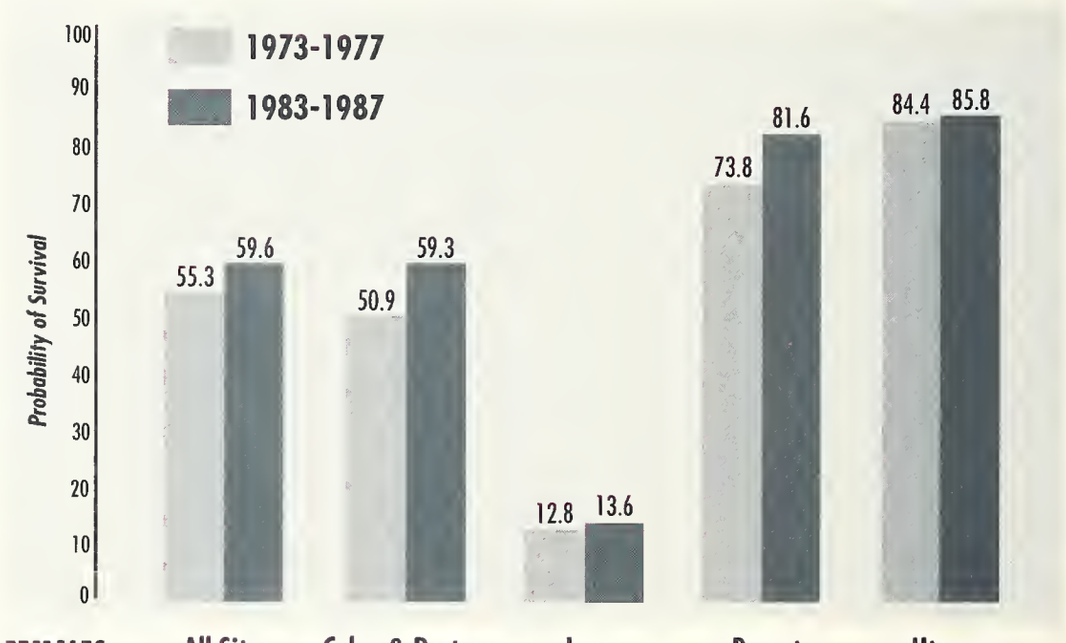
TYPE	# OF CANCERS	% OF TOTAL
PROSTATE	2300	28.4
LUNG	1350	16.7
COLON & RECTUM	1050	13.0
NON-HODGKIN'S LYMPH.	300	3.7
BLADDER	250	3.1
LEUKEMIA	240	2.9
KIDNEY & RENAL PELVIS	200	2.5
SKIN MELANOMA	190	2.3
ORAL CAVITY	185	2.3
PANCREAS	160	2.0
ALL OTHERS	1875	23.1
TOTAL	8100	

Cancer Deaths in Males

TYPE	# OF CANCERS	% OF TOTAL
LUNG	1150	32.9
PROSTATE	470	13.4
COLON & RECTUM	400	11.4
NON-HODGKIN'S LYMPH.	150	4.3
LEUKEMIA	145	4.1
PANCREAS	130	3.7
ESOPHAGUS	100	2.9
BLADDER	95	2.7
BRAIN	90	2.6
KIDNEY & RENAL PELVIS	85	2.4
ALL OTHERS	685	19.6
TOTAL	3500	

FIVE-YEAR RELATIVE* SURVIVAL RATES FOR CANCER IN IOWA





Rates are the ratio of observed survival rate to the expected rate for a group of people in the general population

Survival from cancer in Iowa has been increasing among males and females for all sites as well as for the most common sites.

Fortunately for Iowans, the chances of being diagnosed with many types of cancer can be reduced through positive health practices such as smoking cessation and healthful dietary habits. Early detection through self-examination and regular health check-ups can dramatically improve survival and opportunities for effective cancer treatment. The 1990s have shown increasing numbers of early stage breast and prostate cancers, largely the result of early detection due to screening. Preventive measures and early detection should continue to show positive changes in the Iowa cancer data, including increased survival.

inclined to pay them rather than fight them or contact a lawyer.

A year or two after the overpayment is assessed, the carrier may conduct an audit focused on the issue for which an overpayment was assessed. (This audit may occur without the provider's knowledge.) If the audit revealed any similar problems, the carrier considers referring the case to the U.S. attorney for possible criminal investigation or civil monetary penalties.

If you receive a Medicare overpayment letter — even a very small overpayment letter — contact your lawyer. You may feel that the amount involved is too small to justify a legal expense, but almost all clients involved in a major investigation wish they had called their lawyer earlier in the process.

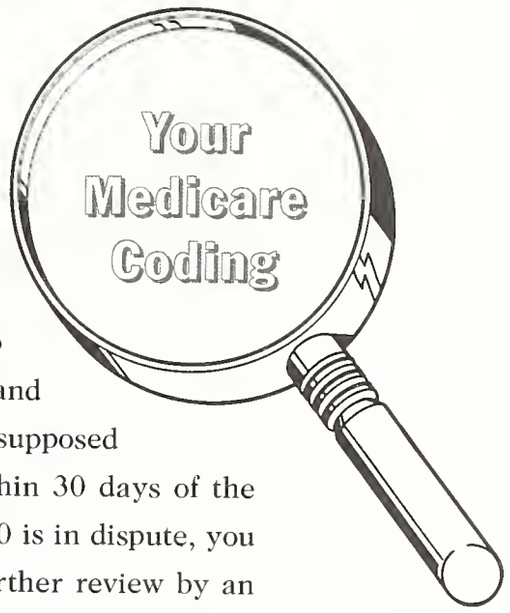
Depending on the circumstances, the call may be quite short, but at the very least you should confirm that your understanding of the billing rules is correct. You may also want to consider fighting the overpayment.

Appealing overpayments

After receiving an overpayment letter for more than $100, you have six months to file an appeal. Surprisingly, filing an appeal does not postpone your repayment obligation. Unless you repay the overpayment within 30 days, it accrues interest at a relatively high rate. If you choose to appeal, you may choose one of three types of hearings — an "on the record" hearing where a hearing office reviews written documentation; a telephone hearing or an in-person hearing.

For any large sum, telephone or in-person hearings may be preferable because they allow you to respond to the officer's concerns. These hearings are quite informal and the carrier often does not send a representative. You may choose to use a lawyer or you may represent yourself.

If you represent yourself, it is advisable to consult briefly with your lawyer beforehand to confirm that you understand the billing rules. You are supposed to receive a decision within 30 days of the hearing. If more than $500 is in dispute, you have the right to seek further review by an administrative law judge.



The carrier concluded that if enough claims were audited, several more incorrect claims would likely be detected.

Don't get a false sense of security if an audit finds only three or four improper claims. A client of our law firm challenged an overpayment involving about a dozen patients. The hearing officer ruled that the vast majority of the bills were correct and that only three contained errors.

Understandably, the provider viewed this hearing as a victory; the carrier disagreed. The carrier concluded that if enough claims were audited, several more incorrect claims would likely be detected. (With penalties of $5,000 per claim, the penalty for ten claims discovered by the carrier would be $50,000!) While the government is usually reasonable in selecting which cases to prosecute, if it chooses to pursue a case involving only a handful of claims, it may.

Preventing trouble

Look for patterns in rejected claims and ask your billing personnel what types of claims were most commonly rejected. You may be able to detect potential problems before an audit if you know what types of your claims are most frequently rejected or sent back for additional documentation.

continued

A monthly meeting to discuss claim rejections may be an excellent idea.

Outside consultants, compliance programs

You should consider using an outside consultant to conduct routine billing audits. While it may seem expensive, the cost of a few improper claims which subject you to a fine or penalty will dwarf the audit cost.

A routine audit may also demonstrate your intent to comply with the rules. Prosecutors recognize that the billing rules are complex. If you are making a good faith effort to comply, you are much less likely to face penalties for any mistakes.

If you are making a good faith effort to comply, you are much less likely to face dramatic penalties for mistakes.

Another good idea is developing a compliance program. A compliance program can help detect trouble and reduce the penalties in the event the government ever detects billing problems. The goal is to make certain that employees completely understand the billing rules and feel comfortable raising questions if they think any billing problems exist. It is wise to encourage billing personnel to ask lots of questions.

A compliance plan need not be expensive or bureaucratic. It should be a user friendly method of ensuring employees are aware of relevant regulations.

Common sense may not prevail

Never make the mistake of assuming that common sense will prevail. There are many billing rules which are extremely counter-intuitive. For example, many services provided by non-physician personnel are billed using the physician's number because the service is considered "incident to" the physician's service.

Many of our clients have been surprised to discover that the services they rendered did not meet the very strict rules governing "incident to" services.

For example, one of the rules is that only services rendered by an employee can be considered "incident to" a physician's services. Services rendered by a nurse, medical assistant, physical therapist or other non-physician who is an independent contractor cannot be billed under the physician's provider number. If you are unfamiliar with the rules governing "incident to" services, contact your health care attorney.

In these situations, the carrier may attempt to collect an overpayment from you even though you provided legitimate, useful services.

While common sense might lead you to believe that the carrier will not try to collect a refund when you have provided medically necessary services, most carriers believe their contract requires them to apply the billing rules, not common sense.

The bottom line is that during the next few years you can expect to see a dramatic increase in the number of audits and investigations into health care entities. Now is the time to try and reduce the chance you will be a target. IM

What to do if an investigator is at your office door



Common sense advice that may help you make the best of a bad situation

Despite your best efforts, it can happen to any physician. In fact, it is likely that at some point in your professional life you will have contact with a government investigator, whether that individual is investigating you, a colleague, a staff member or a patient.

Here are some tips based on our experience with physicians who have been in this decidedly unpleasant situation:

1. Who are they?

Verify the agent's credentials. Get a business card or a copy of the ID for each person present.

2. Mum's the word

Your strongest weapon is a polite silence. An agent's strongest weapon is your fear or overconfidence because either one can prompt you to talk when you shouldn't. Silence can be awkward and agents expect you will attempt to fill the silence by explaining your position.

After consulting your attorney you may, under some circumstances, decide that your strongest defense is to explain your case to the agents. That is a big decision and it generally should not be made during the first day of the investigation.

3. Call a lawyer

As soon as you are aware of any investigation, call a lawyer. You will want to review your rights and consider the strengths and risks of each course of action.

Most importantly, you may be able to protect some information by invoking a privilege. (Privileges include patient confidentiality, peer review, the Fifth Amendment 'right to remain silent' as well as attorney/client and other similar privileges.)

continued

Never release any information to an investigator unless:

- The agent has a warrant, OR
- You have spoken with your attorney

If you improperly release information, you may be violating patient confidentiality laws. Also, some of the information may be legally privileged.

continued

4. You aren't required to submit to an interview.

In general, a government agent cannot require anyone to submit to any type of interview. In an investigation, always speak with a lawyer before deciding whether to talk to an investigator.

5. You can't forbid your employees from speaking with an agent.

If you attempt to prevent your employees from speaking with the government, you may be charged with obstruction of justice. However, it is perfectly legal for you to inform employees of their rights. Your legal counsel should provide you with a memo to every employee, outlining the following points:

•Every employee has a right to choose whether to speak with an agent. The employer may not prevent an interview, but the agent may not require one.

• If the employee chooses to submit to an interview, that employee has the right to dictate any terms he or she chooses. For example, the employee may have an attorney present.

In some situations, the company may be required to provide an employee with his or her own attorney at company expense. The employee may also insist that a friend or colleague be present for the interview.

•Every employee should be told to tell the truth. Lying to a government agent is a crime.

•No one should ever attempt to destroy documents or hide evidence during an investigation. Employees may believe that these acts help the provider or the employees. In fact, such conduct is a crime and damages the credibility of everyone involved.

6. Agents may contact your employees at home.

Advise employee of this possibility. Agents suspect people are more comfortable there and may feel less pressure.

7. Don't try to "clear everything up".

When an investigation begins, your first impulse may be to conclude that it is a misunderstanding which you can clear up with a meeting. RESIST THIS IMPULSE. Speaking prematurely with a government agent in what you perceive to be a spirit of cooperation may have disastrous results.

•Since Medicare rules are complicated, you may have violated them without even knowing it.

•To some investigators, there is no such thing as an innocent mistake. They see fraud where most of us see confusion.

8. Keep a record of information you release and notes of every conversation you have.

After you have contact with the government, call your lawyer immediately and repeat every detail you can recall. It is wise to dictate a memo to your attorney recording the facts and mark it "Attorney/Client Privilege, confidential". IM

Emergency Physician Practice Opportunity

Dubuque Emergency Physicians, P.C. *is a 4-member group practice that has provided 11-years of care at Mercy Health Center, Dubuque, Iowa. Mercy Health Center, St. Joseph's Unit at Dubuque is a 410-bed medical center that services a tri-state area. We are seeking a BC/BP Emergency trained physician or a boarded physician with extensive emergency experience for a full-time position. Become the fifth member of our team in a modern ED with 23,000 annual visits and weekend double coverage. This position offers exceptional compensation and benefits, plus a short time to partnership. Dubuque, Iowa is a family oriented community located on the scenic Mississippi River. You will enjoy a lifestyle unsurpassed by any other region in the country. Dubuque, Iowa offers a matchless public and parochial school system, a strong and growing economic base, and ample recreational and cultural activities.*



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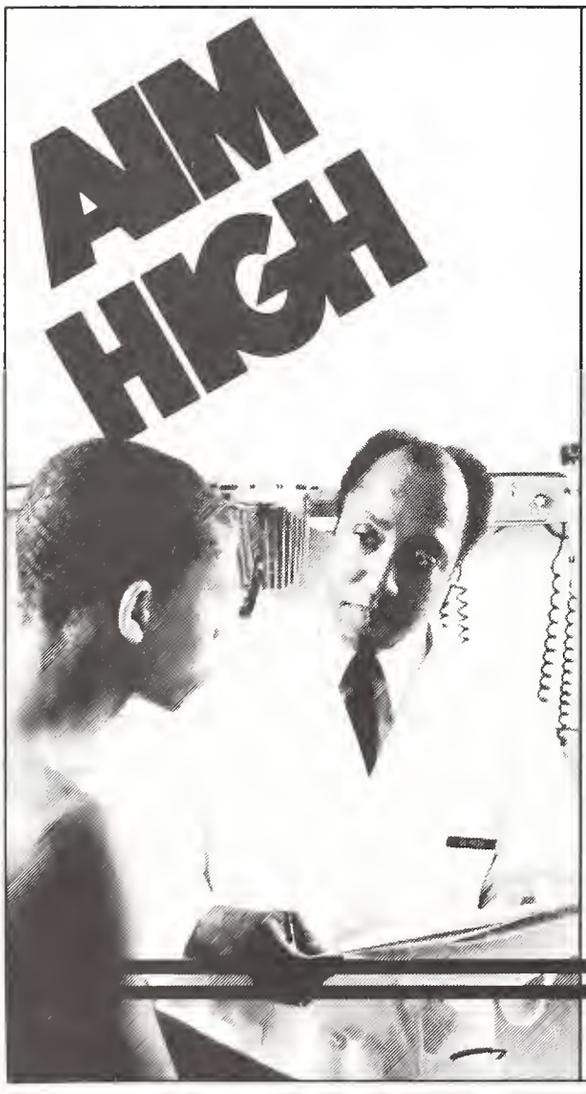


"Break the Silence Begin the Cure"

The Iowa Medical Society still has domestic violence videotapes available to any IMS physician for loan or purchase ($20). The 27-minute video has received rave reviews from physicians and other health care professionals, clinic managers and domestic violence advocates.

The video contains Iowa domestic abuse experts and is aimed at educating Iowa physicians on how to manage victims of domestic abuse.

To borrow or buy the tape, call Chris McMahon, IMS director of communications at 515/223-1401 or 800/747-3070.



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AIR FORCE

The Journal
of the Iowa Medical Society

Neurosurgical intensive care for severe head injuries

S. Randy Winston, MD

A recent survey of critical care management of comatose head-injured patients in *Critical Care Medicine* indicates a significant disparity between the best-available level of care and routine care.[1] The editorial accompanying the paper takes the neurosurgical/neurological organizations to task for not making readily available up-to-date technical material and study results.[2]

The approach and the management of neurologically injured patients varies even within groups of neurosurgeons. This paper hopefully serves to answer the question posed by my critical care colleagues as to what is currently the best-available treatment for these patients and to indicate the rationale used in the new care-delivery paradigm you have begun to see implemented in the special care units here and elsewhere.

Treatment of severe head injury is changing from traditional management to cerebral perfusion pressure (CPP) management.[3] Traditionally we sought to treat intracranial hypertension with hyperventilation, sedation and mannitol. Because we have learned elevated blood pressure indicates brain stem ischemia, we know the importance of maintaining BP and not treating hypertension.

Operative treatment hasn't changed much over time with neurosurgeons removing clots or hemorrhagic mass lesions. However, the development of trauma systems has increased the number of severely head injured survivors who are admitted to critical care units and require very consistent intensive care management. Here is where the variation occurs. Much of our intracranial pressure (ICP) management has led to adverse results. Hypotension and hypoxia created by our ICP and blood pressure management led to grievous outcome.[4,5]

There appears to be confusion between cerebral blood flow (CBF) and cerebral blood volume (CBV).[6] Frequently in head injury they are treated as if they were the same. High CBF does not necessarily mean high CBV. Though traditionally believed that CBF is the culprit, study has shown that the probability of survival is increased with elevated CBF. It is now believed that maintenance of CPP, where CPP= mean arterial pressure-intracranial pressure (MAP-ICP), minimizes the risk of ischemic episodes and optimizes autoregulatory function.

Ischemic protection

We begin with the prompt resuscitation of the patient without specific treatment for intracranial hypertension unless the patient demonstrates signs of transtentorial herniation or progressive neurologic deficit not referable to an extraordinary cause. If these circumstances are noted, aggressive treatment of intracranial hypertension including hyperventilation and mannitol administration (after adequate volume resuscitation) is instituted.

Only short-acting agents for neuromuscular blockade should be used for intubation or to prevent the patients from hurting themselves.[7] Hypotension must be avoided or corrected immediately with maintenance of the MAP >90mmHg throughout the patient's course.[8] There is no reason not to use pressors if volume expansion is unsuccessful. These patients should have at minimum a central venous line and preferably a Swan-Ganz catheter, particularly if multiply traumatized. The best vascular expander is red blood cells, though albumin is useful.

If the blood pressure remains unstable

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for March 1996.

S. Randy Winston, MD
Dr. Winston is a neurosurgeon with Neurosurgical Services, LLP in Des Moines.

Neurosurgical intensive care for severe head injuries

continued

despite normal CVP or PCWP on pressors with a hematocrit of 30 or less, the patient is probably a candidate for red cell transfusion. The use of hypertonic saline should also be considered as it has been shown to improve cerebral oxygen delivery and reduce ICP after hemorrhagic shock.[8,9]

ICP monitoring

Who should have their ICP monitored? Certainly it is appropriate in severely head injured patients with abnormal CT scans. It also may be used in patients with normal CT scans if two or more of the following features are noted: age over 40 years, systemic blood pressure <90mmHg, or motor posturing.[10] Although it is not indicated in mild or moderate head injury (GCS>8), it certainly can be used in conscious patients with traumatic mass lesions.

The ability to remove CSF favors the placement of a ventricular catheter for monitoring but the use of epidural or intraparenchymal monitors is common. The threshold for initiation of treatment is controversial but ICP 20-25 appears to be favored. ICP monitoring should be frequently corroborated with clinical exams and CPP data.

Cerebral perfusion pressure management

CPP (MAP-ICP) should be maintained at 70 (Normal 80-100; Range 60-150), though we may need to elevate it higher under certain circumstances.[11] CPP management optimizes autoregulatory function since patients do better with higher CPPs.

CPP-based treatment also facilitates ICP control for patients with intact autoregulation and doesn't appear to exacerbate intracranial hypertension in most patients with impaired autoregulation. It improves volume tolerance to mass lesions and diminishes the risk of delayed ischemia secondary to vasospasm which occurs in 25 to 33% of severe head injured patients.

Hyperventilatory therapy

Chronic hyperventilation as prophylaxis with pCO_2 <25 torr should be avoided in the first five days after severe brain trauma in the absence of increased intracranial pressure. Especially in the first 24 hours, hyperventilatory therapy (HVT) should be avoided since it can compromise cerebral perfusion during this time of reduced CBF.[12] As mentioned, HVT may be needed for brief periods during neurological deterioration or longer if intracranial hypertension is refractory to the standard measures employed. If HVT is used more aggressively, jugular desaturation monitoring may be helpful in the identification of cerebral ischemia and serve as a guide to the extent of the HVT.[13,14]

Mannitol

Mannitol appears to be more effective in small boluses. It is used prior to ICP monitoring for indications of transtentorial herniation or progressive neurological deterioration. Hypovolemia must be avoided with replacement of outputs ml for ml and maintenance of euvolemia should avoid serum hyperosmolar states 320 or higher. To assure euvolemia, all outputs should be replaced plus 30 ml/hour for insensible loss in the afebrile patient.

Corticosteroids

Corticosteroids are not recommended in these patients. They neither improve outcome nor reduce intracranial pressure.

Seizure prophylaxis

Delayed posttraumatic epilepsy (occurring >7 days after injury) occurs in about 5% of patients with closed head trauma, 15% of adults with depressed fractures, 25% of those with early epilepsy and about 35% with intracerebral hematomas. Anticonvulsant prophylaxis after the first week is not recommended. They may prevent seizures in the first week but there is no evidence their treatment improves outcome.[15,16] We prefer to use prophylaxis at least the first week after severe head injury, continuing in patients with a good chance of later epilepsy.[17]

Metabolic therapy

Nutrition is important early in the course of treatment since negative nitrogen balance can rapidly develop as a result of hypermetabolism and hypercatabolism. Calorie and

protein intake in substantial amounts is required to prevent muscle atrophy and weight loss. A nasogastric tube is usually in place and early enteral feeding can be instituted if bowel sounds are present.

If bowel sounds are not present after 24-36 hours or if the tube hasn't migrated into the jejunum as seen on plain x-ray, a nasojejunal tube can be placed under fluoroscopic control. TPN is usually used in multiple system injury including abdominal trauma in patients who cannot tolerate any eternal feeding for 4-5 days.[18,19]

Barbiturate therapy

High dose barbiturate therapy should be considered in patients who are hemodynamically stable when their intracranial hypertension is refractory to maximum medical treatment.[20] However, if the cardiac output is reduced and systemic arterial blood pressure declines as a result of the barbiturate, a net reduction in CPP could aggravate intracranial hypertension. The effect on outcome is not clear.[21]

Research and alternative treatment including protective agents and new monitoring techniques continue to be developed. Within the past few months a document was published dealing with the topic of this paper. Funded by the Brain Trauma Foundation and written by representatives of the Joint Section on Trauma of the American Association of Neurological Surgeons (AANS)/Congress of Neurological Surgeons (CNS), it is a summary of what is known in the literature about critical care treatment of severe head injury in adults. It promises to define standards, guidelines and options in treatment. In view of the complexity and controversy inherent in such a document, it has been in preparation for over two years. Thus far, the sixth version of this document has been approved by several organizations including the American Association of Neurological Surgeons, American Association of Neurology, American College of Emergency Physicians and the American Society of Neuroradiology.

References

References noted in this article are available from the author or the editors of *Iowa Medicine*. IM

Three Minature Medical Gems *(Contributed by Charles Maplethorpe, MD, Toledo)*

The one minute respiratory evaluation—The equipment needed to do this test is a timepiece that measures one minute. Timing begins when you take a deep breath. Hold it as long as you can and slowly exhale. Then count the number of breaths you take until one minute has expired. The number of breaths you take is the answer to the test. If the number is 0, you are 100%. If the number is over 12, you should see a respiratory therapist for more definitive testing.

Rehab for an injured ankle—One of the classic policies in physical therapy is motion against resistance. In rehabilitating an injured ankle, one method of using that policy is to place a swim fin or flipper on that foot. Then attempt exercising the ankle when it is immersed in a bathtub of water or in a whirlpool. If a whirlpool is used, don't use the jets.

Reduction of subluxation of the sacro-iliac joint—Most orthopedic specialists do not consider subluxation of the sacro-iliac joint to be a proper diagnosis. However, when there is pain and tenderness over the joint, when moving from a sitting position to standing is difficult and painful and when the gait reveals a "lumbar tilt," the best diagnosis is subluxation of the sacro-iliac joint. To accomplish reduction: with the patient in the supine position, flex the lower extremities up onto the abdomen (the asymptomatic side first), then straighten both extremities so they are at a 90° angle with the spine. Keeping the extremities straight, lower them to the examining table. If the lowering causes severe pain, assist lowering the extremities. This maneuver usually results in immediate relief.



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Solitude is being by yourself and not feeling alone. Loneliness is being—and feeling—alone. Joseph Roux, a 17th century French priest said, "solitude vivifies; isolation kills." Loneliness has a connotation of seclusion, friendlessness and estrangement from society. Solitude is a state of mind and heart. Emerson declared, "There is one means of procuring solitude which to me, and I apprehend to all men, is effectual, and that is to go to the windows and look at the stars."

Loneliness may lead to a depressed or sad mood that is a normal response to specific life experiences, e.g., loss or disappointment. This is not to be confused with the clinical state of depression which involves emotional, cognitive, behavioral or somatic regulation. A sad or depressed mood is only one of the many characteristics of clinical depression.

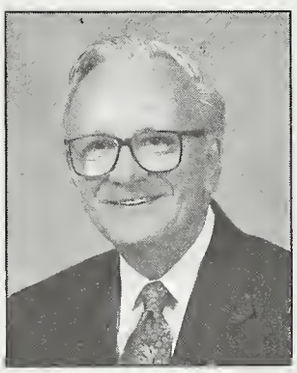
Let us direct our attention to solitude. Philosophers and poets have reflected upon solitude and agree the key attributes are a time for reflection and introspection; a time to be in touch with one's true self; an adventure in philosophy; a time to "venture forth and explore the essence of individual life." (F. Martilbañez) Solitude is voluntary seeking of inner fulfillment—a state of heart and mind.

When we possess inward solitude the fear of being alone is not present, for we know we are not alone. The Bible records numerous times when Jesus withdrew voluntarily for periods of prayer and reflection; there are writings of political or war prisoners' experiences of solitude, e.g., Dietrich Bonhoeffer, Aleksandr Solzhenitsyn. Richard Foster, in his book *Celebration of Discipline,* states "the fruit of solitude is increased sensitivity and compassion for others. There comes a new freedom to be with people. There is a new attentiveness to their need, new responsiveness to their hurts."

All of us can take advantage of little solitudes that fill our day—hearing the cheery song of a bird early in the morning, stopping to admire and smell a beautiful rose, or just during the walk from the car to the office. Some prefer to develop a "quiet place"—a special place one finds conducive to self-reflection. Others prefer to seek formalized retreats.

Solitude is truly a discipline that seems to make us better persons.

Ponder these things. Solitude is truly a discipline that seems to make us better persons. We physicians see all the joys and vicissitudes of life. They can be better understood if we reflect upon our own inner self; that our outward action will be more ideal within the tenets of a wholesome life of serving our patients, our friends, our family, society as a whole and, most important of all, ourselves. IM



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Could you infer a Niagara?

Standing at the lip of Niagara Falls, I recalled my first view of the Falls 40 years ago when on a heavily-snowing cold December night my wife and I trudged to that very point and thrilled not only at the grandeur, but at having the phenomenon all to ourselves. A geologist, though, might foretell the erosion of the water-washed edge; a hydraulic engineer, estimate the electrical power that could be generated; a sailor, ponder how to sail from the higher level of Lake Erie to the lower Lake Ontario without facing these falls; a daredevil, scout the edge for the best spot to aim one's barrel; a photographer, observe the play of light and mist; honeymooners, revel in erotic impulses.

I remembered a brief passage from a Sherlock Holmes story, *A Study in Scarlet*, in which Holmes tells Dr. Watson: "From a drop of water, a logician could infer the possibility of an Atlantic or Niagara without having seen or heard of one or the other." The matter of inference having arisen, I then thought of an amazing sentence that has long beguiled me. It is from the one-page article in *Nature* (April 25, 1953), in which Watson and Crick (not the same Dr. Watson, sad to say) described the double-helical structure of the DNA molecule. That amazing brief report deals almost entirely with technical considerations for the configuration they adduced. But one sentence displays their prescient power of inference: "It has not escaped our notice that the specific pairing we have postulated immediately suggests a possible copying mechanism for the genetic material." In a long editorial, several months later, they had freedom to elaborate and project the significance of their findings—and even those extended inferences likely fall short of the long-term implications for research, knowledge, therapy, ethical conundrums—an exploding cornucopia of insight, opportunities and dilemmas.

How do physicians develop the crucial skill of inference-making?

Physicians must always gather quickly a limited amount of data, then infer from it a diagnosis, and further infer a mode of therapy and a persuasive style of presenting it. From the color of the sclera we may infer jaundice or carotenemia; from a radiographic shadow, a fracture or pneumonia; from a patient's gait or speech, Parkinsonism or myxedema; from the affect and life situation, grief or anguish; from the patient's story and attitude, whether cooperation with therapy can be expected; and so on.

How do physicians develop the crucial skill of inference-making? Surely not by taking a course with that title, but we can infer that such skill develops in courses with other titles (math, logic, philosophy, politics, history, grammar, the sciences, literature, fine arts) and from life experiences. Attention to the rational process of inference as one engages in medical work will surely make more fulfilled and effective physicians. IM



Richard Caplan, MD

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Fort Dodge 50501
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Iowa Medicine

JOURNAL OF THE IOWA MEDICAL SOCIETY | APRIL 1996

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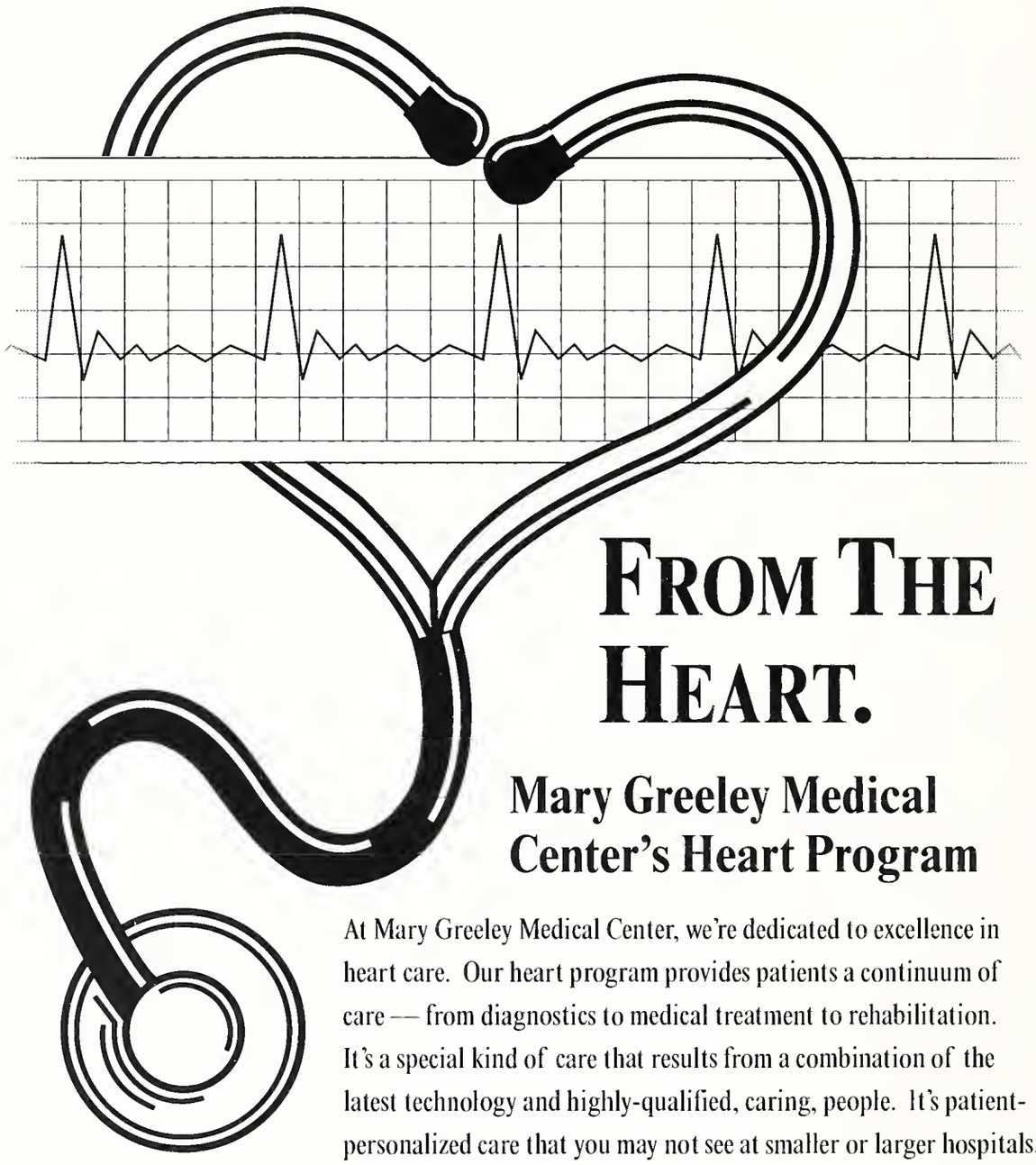
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HCFA's 'correct coding' initiative is causing a stir among Iowa physicians. What is it and what does it mean? Page 150

CARE FOR THE HEART.



FROM THE HEART.

Mary Greeley Medical Center's Heart Program

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IMS *DEADLINE* news

APRIL, 1996

Late-breaking news of interest to Iowa physicians

●**MEDICARE DENIALS DUE TO THE ADMINASTAR** correct coding initiative for the first two months of 1996 in Iowa total 7,720. The IMS is continuing to work with the AMA to resolve the numerous issues associated with AdminaStar. For more details, see story on page 150.

●**MEDICARE'S E & M CODE UTILIZATION DATA** is available for the first six months of 1995. To get the utilization percents (Iowa and nation), send a self-addressed envelope to IMS, ATTN: E & M Data, 1001 Grand Avenue, West Des Moines, IA 50265. Be sure to include a note regarding which specialties you would like to receive. For more than three specialties, please send a self-addressed 8 1/2 X 11 envelope.

●**THE IOWA FOUNDATION FOR MEDICAL CARE** has been selected by HCFA as the new Medicare PRO for Illinois. IFMC's new $10 million contract begins April 1 and extends through May 31, 1999. IFMC will be responsible for utilization and quality improvement strategies for more than 1.5 million Medicare beneficiaries in Illinois.

●**DES MOINES PHYSICIAN DR. MICHAEL ABRAMS** was interviewed in late March on the Montel Williams show and the Phil Donahue show. Dr. Abrams is director of combined specialties at Broadlawns Medical Center. His topic on the talk shows was methamphetamine. Dateline NBC also interviewed Dr. Abrams recently regarding Iowa's "crystal meth" epidemic.

●**A CAMPAIGN IS UNDERWAY TO ENDOW** the Richard M. Caplan Chair in Biomedical Ethics and Medical Humanities at the UI College of Medicine. Dr. Caplan, a longtime columnist for *Iowa Medicine*, is retiring in July, 1997. The Caplan Chair will enable the college to support the work of nationally recognized faculty members in biomedical ethics and medical humanities. For information on making a gift or pledge to the endowment, contact John Anderson, MD in Boone or John Strauss, MD in Iowa City.

●**HATS OFF TO ALL THE IOWA PHYSICIANS** who contacted their legislators and wrote letters to Iowa newspapers regarding legislation requiring Iowa physicians to test all pregnant women for group B strep. Your grass roots efforts on this bill were tremendously successful. As of press time, the bill died in caucus and IMS representatives were watching for the proposal to emerge in the form of amendments to other bills. (Don't forget to thank your legislator for his or her support.)

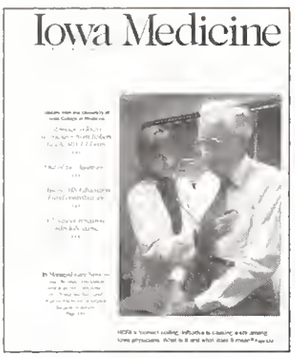
●**A RESOLUTION ON SPECIALTY SOCIETY REPRESENTATION** in the IMS House of Delegates will go to the House at the 1996 Annual Meeting April 20-21 at the Embassy Suites. The bylaws change will be considered by the House at its Saturday, April 20 session so that specialty society delegates could be in place for the Sunday, April 21 House session and annual elections. For more information on qualifications and procedures for specialty society delegates, call Sandy Nelson or Dean Gillaspey at the IMS, 515/223-1401 or 800/747-3070.

●**IN A SURVEY REPORTED RECENTLY IN THE *DES MOINES REGISTER*,** 51% of Iowa physicians said they oppose physician-assisted suicide; 49% said they support it in some cases. This survey of was conducted with assistance from the IMS. Check the May *Iowa Medicine* for more details.

For more information about any *DEADLINE* news item, call Chris McMahon at IMS headquarters, 515/223-1401 or 800/747-3070.

Iowa Medicine

APRIL 1996 / VOLUME 86 / 4



About the Cover

Dr. Viviana Martinez-Bianchi, a UI resident in family practice, examines Merle Melton of Iowa City. Dr. Martinez-Bianchi provided respite service to Medical Associates of Elkader through the UI College of Medicine Rural Physician Support Program.

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An exeerpt from a eommeneement address to the 1995 graduating elass of the UI College of Medieine. ● *LAURIE LYCKHOLM, MD*

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Educational focus for medical students at the University of Iowa is shifting from the classroom to the bedside and the clinic. With the advent of the new curriculum, students will get earlier exposure to medical practice. ● *VERA DORDICK*

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During the past year, over 625 Iowa physicians contributed to the IMS Education Fund. The Fund is a major source of medical student loans and support for public health projects.

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As Iowa's leading center for cancer research and treatment, the University of Iowa faces a dual challenge — pursuing new knowledge while providing advanced clinical services in a changing health care environment. ● *C. LINDON LARSON*

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APRIL 19-20, 1996

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TOPICS

"Status of Laparoscopic Colon/Rectal Surgery"
"Laparoscopic Anti-reflux Procedure"
"Laparoscopic Common Bile Duct Exploration"
"Laparoscopic Splenectomy and Adrenalectomy"
"Cost Containment in Laparoscopic Surgery"
"Laparoscopic Evaluation & Treatment of Adnexal Masses"
"Laparoscopic Herniorrhaphy"
"Laparoscopic Treatment of Peptic Ulcer Disease"
"Laparoscopic Pelvic Reconstruction"
"Diagnostic Laparoscopy: Uses and Pitfalls"
"Pyloric Preservation with Whipple Procedure"
"Resection vs. Bypass"
"What's Here and Now? What Does the Future Hold for Laparoscopic Surgery?"
"Evolution of the Surgical Approach to Pancreatic Neoplasms"
"Pancreatoduodenectomy: Comparing the Total Whipple Procedure vs. Total Pancreatectomy"

ACCREDITATION

As an organization accredited by the Iowa Medical Society for continuing medical education, Iowa Methodist Medical Center certifieds that this continuing medical education offering meets the criteria for Category I credit toward AMA Physician's Recognition Award, provided it is used and completed as designed.

April 19: 7 hours April 20: 3 hours

COST

Physician Fee $150.00
Resident Fee $35.00

CONTACT

Surgery Education Office, Iowa Methodist Medical Center
1221 Pleasant Street, Des Moines, IA 50309 Phone: (515) 241-4076

Now more than ever, ethics must come first

Ethics has been an important part of the practice of medicine for centuries, dating baek at least to the Oath of Hippocrates which was probably written in the fifth century BC. This revered statement of ideals has remained in western civilization as an expression of ideal physician conduct.

A Code of Ethics was established in 1847 by the AMA. Through the years this code has been clarified; the last revision was approved by the AMA House of Delegates in 1980.

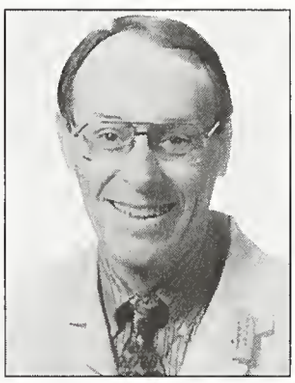
Changes in the health care delivery system further emphasize the importance of medical ethics. Large corporate entities delivering managed care, large HMOs and other large health care systems sometimes have different outlooks. Cost cutting is a primary interest of these large entities but not necessarily for the patient's benefit. The benefit often goes to the corporate coffers and stockholders. These organizations have attempted to enforce "gag" rules on physicians to prohibit them from fully informing their patients of the medical options available. These changes in the structure of health care delivery are real and will continue to evolve. We as advocates for the patients must do our best to see that the ethical practice of medicine is not infringed upon and that these organizations adhere to ethical principles.

Cost cutting is a primary interest of these large entities.

Advances in technology, genetic engineering and assisted reproduction have brought new ethical questions. The highly publicized issues of euthanasia and assisted suicide are well known to all of us.

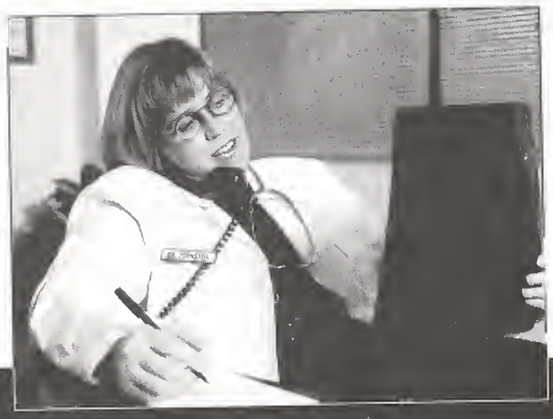
Another important and pragmatic issue to be considered by bioethics is the proper allocation of health care dollars. We can no longer afford ultimate care for everybody. The debate over Medicare is an example. Who gets what kind of care? When should we say enough care has been given or that none is indicated? Oregon should be applauded for efforts to address these issues.

At the December AMA meeting, Cardinal Joseph Bernardin, Archbishop of Chicago, addressed the delegates on the subject of professional values. He urged physicians to renew their covenants with patients and to make sure they were grounded in moral rather than legal or contractual obligations. This is good advice.



JOSEPH HALL, MD

Recently, I received an announcement of a campaign to endow the Richard M. Caplan Chair in Biomedical Ethics and Humanities. This is truly a fitting tribute to Dr. Caplan. He has given dedicated service to medicine, Iowa physicians and the IMS. He is well known for his essays in *Iowa Medicine*. Today our health care values and medical ethics are being seriously challenged. This is a great opportunity to support these values and at the same time honor Dr. Caplan. I urge you to support this endowment fund. IM



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Preparing for a new century



The University of Iowa College of Medicine is preparing for the future and farsighted plans are yielding results. We're pleased with our achievements to date but there is still much to do. We welcome your suggestions of how we can better serve you and the citizens of Iowa.

New leaders round out a strong team

The leadership of the College of Medicine has been strengthened with the naming of five new department heads. We're optimistic about the future with these new leaders and I hope that you may have occasion to join me in congratulating them.

- Dr. Gerald Gebhart is the new head of the Department of Pharmacology. Dr. Gebhart is a professor within the department, having joined the UI pharmacology faculty in 1973.
- Dr. Mary J.C. Hendrix was named professor and head of the Department of Anatomy. Dr. Hendrix is professor and IMMUNO Chair in Research in the St. Louis University Health Sciences Center Department of Pediatrics.
- Dr. Evan Kligman is the new professor and head of the Department of Family Practice. Dr. Kligman was associate professor and head of the Department of Family and Community Medicine at the University of Arizona and director of the Arizona Disease Prevention Center.
- Dr. Carol Scott-Conner was named professor and head of surgery, effective last October. Dr. Scott-Conner came to the UI from the University of Mississippi School of Medicine where she was professor and chief of staff of the University Hospital.
- Dr. Bruce Gantz was named professor and head of otolaryngology in August after serving as interim head of the department since 1993.

Linking with Iowa's family practitioners

Dr. Kligman, the new head of family practice, is one of the outstanding leaders in family medicine today. We're looking to Dr. Kligman to strengthen our links with family physicians throughout Iowa. He is already playing an important role in helping the department become the "hub" of a statewide integrated educational and research network.



ROBERT KELCH, MD

More than 30% of UI medical grads chose family practice, double the national average.

High marks for primary care training

A record number of students in the 1995 College of Medicine graduating class—more than 62%—entered careers in the primary care specialties. For the third consecutive year, more than 30% of UI medical graduates chose family practice, double the 1995 national average. We're very proud of our national rankings in students opting for primary care, but recognize the need to work harder to help Iowa meet care needs.

continued

Dr. Kelch is dean of the UI College of Medicine, Iowa City. He is a pediatric endocrinologist.

continued

New grant gives College a research boost

The College was recently awarded a four-year, $2.4 million grant from the Howard Hughes Medical Institute (HHMI) to support recruitment of outstanding new faculty and to fund a series of initiatives and pilot studies in biomedical research. UI President Mary Sue Coleman, said "this recognition and award from the HHMI, the leading private medical research institute in the world, reflects the growing accomplishments and national stature of the UI College of Medicine."

Hitting some research high notes

The College has worked painstakingly this year to add to the growing body of new knowledge. Important discoveries in the past year include:

- the discovery that sleep apnea can cause fluctuations in blood pressure and oxygen levels even while awake, thus creating a greater risk for cardiovascular disease;
- mapping genes that are linked to a number of inherited eye diseases, the most recent being a gene for a form of age-related macular degeneration;
- findings that childhood obesity can be a heart attack in waiting. This study was part of the UI Muscatine Coronary Risk Factor Project;
- determining that post-menopausal women benefit from combination hormone therapy;
- releasing a report on 20-year cancer statistics in Iowa, showing that cancer cases increased only 6%, largely attributable to early diagnosis;
- the discovery that in certain patients, surgery can dramatically reduce the risk of stroke;
- the discovery of new clues about the brain and its functions, including the finding that people with schizophrenia may have abnormalities in the thalamus, and that recognition of fear is linked to the amygdala;
- findings about bacterial mechanisms that trigger gene expression, causing certain deep sea fish to glow. These same mechanisms may be a key to the pathogen that infects the lungs of patients with cystic fibrosis.

We continue our efforts to see that the UI Cancer Center becomes a National Cancer Institute-designated Comprehensive Cancer Center. This will identify our center as a national resource in the study and treatment of cancer in rural populations.

Too many physicians?

Reports from the PEW Charitable Trust Health Professions Commission call for reducing medical school enrollment by 20-25%; an Institute of Medicine study recommends freezing existing class size. The Association of American Medical Colleges questions the wisdom of depriving Americans of careers in medicine before addressing the need to limit the number of international medical graduates training in this country. We are studying these reports with respect to the number and specialties of physicians Iowa needs. We will carefully address the issues of overspecialization and maldistribution of graduates before we consider reducing enrollment.

Excellent investment for Iowa

The College is preparing for the next century with an ambitious capital planning process that will be an excellent investment. We're generating a plan for constructing long needed collegiate educational facilities, renovating laboratories and adding vital new capacity for biomedical research.

The College is on the move. We invite you to participate in charting our course for the future. IM

Not afraid of an uncertain future



Editor's note: This editorial was excerpted from the author's commencement address to the 1995 class at the UI College of Medicine.

Now you are ready to take the next step in your education in becoming a doctor. Though you may be frightened, I know you and I am not. First of all, I am not frightened that you will have trouble with the huge volume of information, because at its core is a better way to take care of patients. That is your goal. I also know that you are a class who enjoys a challenge, and that you will welcome the chance for intellectual stimulation. For many of you, the science and the rapid pace of change inspire you and kindle your love for this discipline which means so many things, but is simply called "medicine".

I am certainly not frightened that you will be caught up in the medical economics game, but it is something to deal with and something that is part of life in medicine in the 21st century. It is something to learn about so that the control is always yours, so that you may work with it and be part of it. I know you and I know you have the resources to do just that. I also know that your respect and devotion to the patient, first and foremost, will never allow anything—even something as potentially powerful as money—come between you and the delivery of the excellent patient care at which you have become so adept. Nothing can come between you and your motivation for medicine. Nothing is as powerful as that relationship between you and your patient.

I'm not frightened that you will be consumed by medicine, so that you have no other life, again, because I know you. Yes, you will put in long hours, especially in your residencies, and you will devote considerable energy to your patients, but that time and energy is part of your devotion to the rest of your world. It nurtures you as a person as you nurture it. Each time you see and interact with a patient, you learn something about the patient and about life and about yourself. Through those interactions, you broaden your vision, you become a self-realized, self-actualized person; in doing that, you enrich your relationship with your family, your friends, your partners and the world around you.

Nothing is as powerful as that relationship between you and your patient.

You have chosen to contribute to the lives of others and you will always find that giving begets giving. I have seen and heard about the giving many of you have already done—your generosity toward each other, your patients and the community. So I know that you have already learned the joy of giving, and that is why I am not frightened, not frightened at all—for you. IM



LAURIE LYCKHOLM, MD

Dr. Lyckholm is a fellow at the MacLean Center for Clinical Medical Ethics at the University of Chicago. She was a part of the UI medical staff, Department of Internal Medicine, from 1992-95.

MANAGED CARE

news you can use

Articles on Iowa's physician-run organizations begin in May issue

How are Iowa physicians coping with changes in our health care delivery system? Beginning next month, *Iowa Medicine*'s managed care pages will be devoted to a series of articles on physician-run managed care organizations in Iowa. If you know of any innovative arrangements organized by Iowa physicians, please call Barb Cannon or Chris McMahon at the IMS, 515/223-1401 or 800/747-3070.

IMS, payers reach agreement on managed care principles

Representatives of the Iowa Medical Society, the Association of Iowa Hospitals and Health Systems and large insurers including Principal, the Blues and John Deere announced the development of the **Prineiples of Agreement for Managed Care** at a recent press conference at the Iowa Statehouse. Dr. Kevin Cunningham, chair, IMS Committee on Legislation, told reporters Iowa is one of the first states in the nation to develop a blueprint for the rapid growth of managed care. The Principles, published in the February *Iowa Medicine,* address issues including advance notice to providers when new managed care networks are being formed, how providers apply to such networks, disclosure of selection criteria and patient access issues such as location of providers. The Principles were designed as a guide in a changing environment; providers and payers have already scheduled additional discussion of issues which have emerged since the Principles were signed. The AMA has requested IMS permission to provide the Principles as a model document for other medical societies.

AMA advises the nation's physicians to beware of 'gag' clauses

The AMA's Council on Ethical and Judicial Affairs, which maintains the AMA's Code of Ethics, has declared gag clauses an "unethical influence in the physician-patient relationship". Gag clauses have been found in several Iowa contracts. They are provisions which prevent physicians, either explicitly or implicitly, from giving patients information about treatment options that may not be covered by their health plans. In some cases, the clauses may prevent physicians from referring very sick patients outside their health plans. Asking patients to make decisions without adequate information is "an absolute violation of informed consent requirements", the AMA states. The AMA is calling on managed care plans to submit their contracts for AMA review to determine if they interfere in the patient-physician relationship. Rep. Greg Ganske, a Des Moines plastic surgeon, recently introduced federal legislation to address the problem. Any Iowa physician who suspects a contract contains a gag clause is urged to call Barb Cannon at the IMS, 800/747-3070.

IMS schedules two managed care workshops in Iowa

The Iowa Medical Society has scheduled two managed care workshops on critical managed care topics. Phil Beard, author of *How to Negotiate Capitation (Without Losing Your Head)*, will speak on **"Capitation Calculations"** on Thursday, April 18 from 12:30 - 5:00 p.m. at the Methodist Hospital Cancer Center Auditorium in Omaha. To register, call Sherry Johnson at the IMS, 800/747-3070. **"How to Survive under the Milleman and Robertson Practice Guidelines"** will be the subject of a seminar on Wednesday evening, June 5 at 5:30 p.m. at Mercy Hospital Auditorium, Cedar Rapids. Watch your mail for more details.

Capitation is more than a dollar amount

If managing care is really about managing health care budgets, then capitation fits well. Although capitation is often viewed as a dollar amount, it is really a totally new practice arrangement that must be viewed and evaluated as a total package.

Under capitation payment, physicians and other providers are paid a set amount per member per month (PMPM) to provide needed medical (and other) care.

Risk is shifted to providers

If the patient needs minimal or no care, the PMPM payment can be profitable. If the patient needs care or extensive care, the PMPM rate may be inadequate to cover the costs of care. This is the basis of the "risk" concept associated with capitation. This risk is borne by providers, not a third party payer.

When capitation is the method of paying physicians, it is essential for physicians or their practice management staff to know how their income under capitation will compare to their current income. Only with this financial understanding can they intelligently accept, negotiate or reject capitation (or cap) rates proposed to them.

Analyzing proposed capitation rates

Actuaries, financial advisers and practice management consultants have developed a variety of formulas and analysis to assist in evaluating payment under capitation. Two of the most used analysis are:

1. Identify the costs of providing services to patients on a PMPM basis and compare them to the proposed capitation rate, and

2. Compare reimbursement expected under the capitation rate to what would have been received under a fee-for-service arrangement.

Either method requires detailed records of actual costs and utilization data. If a practice does not have that type of data available, it might be advisable to begin accumulating information in a practice management data system that will be useful for this type of analysis in the future.

The American Medical Association recently published "A Guide to Calculating Benchmark Capitation Rates" using their private sector data base. This may be another useful anaylsis tool and is available from IMS.

Capitation a multifaceted concept

Keep in mind that capitation is a multifaceted concept. In addition to analysis of capitation rates, physicians must be prepared for other changes that are necessary in their practice. These include:

- keeping patients healthy so they need fewer and less costly services
- managing efficiency to keep cost of care as low as possible
- managing financial risk
- careful contract analysis
- a clear understanding of what and what is not covered in the capitation rate
- awareness of quality assurance measures
- knowledge of patient copayment requirements
- awareness of ethical implications in assuming financial risk

Capitation is a complex concept, but good reference materials and experienced physicians or consultants can be very helpful.



Only with this financial understanding can they intelligently accept, negotiate or reject proposed capitation rates.

Managed Care Resources available from IMS

WRITTEN MATERIALS

Evaluating Capitation Payments: A Guide to Calculating Benchmark Capitation Rates — AMA publication

Capitation: The Physician's Guide — AMA publication

How to Negotiate Capitation (Without Losing Your Head) — Phillip L. Beard

Compensation Arrangements in Managed Care Organizations — AMA publication

Assuring Appropriate Patient Care Under Capitation Arrangements — American Society of Internal Medicine

Conomikes Managed Care Handbook — Conomikes Report, Inc.

VIDEOTAPES

Managed Care Experts Discuss Compensation in Managed Care — AMA

CASSETTES

Prepaid Health Plans: Compensation — AMA

Physician Reimbursement — Elizabeth Gallup, MD

The IMS has a comprehensive lending library of managed care materials including articles, booklets and audio and videotapes. Call Sherry, ext. 629 at IMS headquarters, 515/223-1401 or 800/747-3070, for more information.

IMS Update

Candidates for IMS offices named

The IMS Nominating Committee has assembled the following candidate slate for 1996-97 elections. The slate will be formally presented to the IMS House of Delegates Saturday, April 20. Further nominations will be accepted from the floor. Elections will be held at the final House session on Sunday.

Candidates for 1996-97 offices

(length of term in parenthesis)

President-elect (1) — Harold Miller, MD
Vice-president (1) — Hunter Fuerste, MD
Trustee (3) — Sterling Laaveg, MD
House Speaker (1) — Donald Kahle, MD
Vice-Speaker (1) — Tom Throckmorton, MD
AMA Delegates (2) — (elect 3) — Clarence Denser, Jr., MD; Bruce Trimble, MD; Donald Young, MD
AMA Alternates (2) — (elect 1) — Michael Disbro, MD; Thomas Graham, MD

•NOTE: Dr. Disbro will resign as District 10 councilor if he is elected AMA alternate delegate.

District Councilors (3-year terms)

- District 2 — Jamal Hoballah, MD
- District 4 — Steven Jacobs, MD
- District 5 — Ross Madden, MD
- District 10 — Michael Disbro, MD
- District 11 — C. David Smith, MD
- District 14 — Stephen Richards, DO

IMS House of Delegates April 19-21

Iowa physicians will gather April 19-21 for the Iowa Medical Society's 1996 Scientific Session and House of Delegates. The entire weekend of activity will take place at the Embassy Suites in Des Moines.

The Scientific Session will begin at 8:00 a.m. Friday and conclude with a Sunday morning panel discussion on teen violence. Dr. John Nelson, a member of the AMA Board of Trustees, will be a special guest for the weekend's activities and will address the IMS House of Delegates Saturday.

The first session of the House of Delegates will begin at 8:30 a.m. Saturday. An orientation session for new delegates will be held at 7:30 a.m. The final session of the House will begin at 10:00 a.m. Sunday and will conclude with election of officers.

Speakers during Friday's Scientific Session will address topics including Graves' Disease, immunizations, vascular disease in the elderly, what's new in oncology and computer technology in medicine.

The Friday luncheon speaker is Martin MacNeill, DO, JD, of Provo, Utah. Dr. MacNeill will discuss medical law and tort reform.

Special events

•IMPAC will host an open house for all physicians and spouses from 6:00 to 9:00 p.m. Friday at the Embassy Suites.

•To commemorate Iowa's sesquicentennial, entertainment at the IMS Annual Banquet will be Michael and Kelly Gee Carey. The Careys are poets and storytellers who perform throughout Iowa The banquet will begin at 7:00 p.m. Saturday, April 20, preceded by the President's Reception.

Policy resolutions on POs, chronic pain

As of press time, the following policy resolutions had been received for consideration by the House of Delegates:

1. CHRONIC PAIN MANAGEMENT *(Introduced by Jackson County Medical Society and District V)* — Asks that the IMS petition the Board of Medical Examiners to establish a task force to draft guidelines for Iowa physicians treating chronic pain with controlled substances and that physicians who follow the guidelines be immune from BME sanctions.

2. LICENSING OF TEENAGE DRIVERS *(Introduced by Dubuque County Medical Society and District V)* — Asks the IMS to pursue legislation which would provide for 'graduated licensing' for beginning drivers.

3. PROVIDER/PHYSICIAN-OWNED MANAGED CARE ORGANIZATIONS *(Introduced by District*

AT A GLANCE

It's apparently getting easier for Iowa teens to purchase tobacco products, according to the Iowa Department of Public Health. In cooperation with local law enforcement, teens attempted to make buys in several areas of the state. Youths ages 11-17 were successful 50% of the time, compared with 45% last year in a similar check.

Des Moines General Hospital has been designated by the Department of Human Services as a center for treating compulsive gamblers. The hospital will receive a state grant of $120,000 to help finance the program.

VIII) — Asks that the IMS request the Iowa Insurance Commissioner to release guidelines and state regulations governing development of physician and/or provider-owned managed care organizations and the names of individuals to contact in the insurance commissioner's office and publish the information in *Iowa Medicine.*

4. DEVELOPMENT OF A PHYSICIAN-OWNED THIRD PARTY ADMINISTRATOR PLAN *(Introduced by Des Moines-Louisa County Medical Society)* — Asks that the IMS form a task force to pursue development of a physician-owned and directed third party administrator plan which would allow physician participation in development of employer-specific health care plans and increase the number of coverage options in the health care marketplace.

5. LIFE INSURANCE FOR VICTIMS OF DOMESTIC ABUSE *(Introduced by Woodbury County Medical Society and District XV)* — Asks that the IMS pursue legislation which would prevent insurance companies from denying health or life insurance coverage simply because an individual had been a victim of domestic abuse.

6. CERTIFICATE OF NEED PROCESS *(Introduced by Woodbury County Medical Society and District XV)* — Asks that the IMS support abolishment of the certificate of need process.

7. FREQUENCY OF PHYSICIAN VISITS TO PATIENTS IN NURSING FACILITIES *(Introduced by Polk County Medical Society)* — Asks the IMS to work with the AMA to petition HCFA to change the required frequency of physician visits to patients in nursing facilities from every 60 days to every 90 days.

8. DIABETES MELLITUS *(Introduced by Marshall County Medical Society)* — Asks the IMS to do all in its power to require that insulin sold in Iowa by prescription only. IM

Resolutions will be submitted for consideration by the IMS House of Delegates April 20-21.

SPECIALTY SOCIETY UPDATE

The Iowa Psychiatric Society Legislative Committee continues to meet every Friday via telephone conference. IPS members attended the American Psychiatric Association Legislative and Public Affairs Conference in early March. Work continues on the Mental Health Advocacy Coalition and the Insurance Division is writing rules to implement an increase in mental health benefits under the standard plan in the group insurance law.

The Iowa Medical Group Management Association has finalized its uniform physician credentialing form for all insurance companies. The form will be sold through IMGMA on a Windows disc.

The American College of Cardiology, Iowa Chapter, held a reception at the ACC meeting in Orlando honoring Philip Habak, MD, the new ACC Governor for Iowa. The ACC Councilors will meet April 20 during the IMS House of Delegates.

The Iowa Association of County Medical Examiners Board of Directors met recently to discuss pending legislation on anatomical gifts and death examination fees being paid by the county of the person's residence.

The Iowa Association of Pathologists held a teleconference to discuss legislation and managed care issues including telemedicine, point of service and HCFA policy on peripheral blood films.

The Iowa Society of Anesthesiologists will hold its Anesthesia Update on Saturday, April 13 at the Marriott Hotel in Des Moines.

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Brainerd Medical Center, P.A.
218/828-7105 or 218/829-4901
2024 South 6th Street, Brainerd, Minnesota 56401

Legislative Affairs

Sioux City physician seeks senate seat

John Redwine, DO, a Sioux City family physician, has announced he will seek the Republican nomination for the 2nd district state senate seat held by Brad Banks. Banks has announced he will not seek reelection.

As of press time, Dr. Redwine had no opponent for the Republican nomination in the June 4 primary. He also did not know who would seek the Democratic nomination.

Dr. Redwine, employed in administration at St. Luke's Regional Medical Center, said his family supports his decision to enter politics and will play an active role in his campaign. A school board member, Dr. Redwine said he's always been interested in politics and has looked for "an opportunity to serve".

He is interested in education issues and is very concerned about the public's lack of trust in government. He also has some ideas about Iowa's tax structure.

"Iowans pay too much taxes. Living close to the border, I've seen Iowa lose industry to Nebraska because of our tax laws. It's time to reverse that trend."

He also believes the voice of medicine will be especially needed in the future when "the federal government starts putting more responsibility in the hands of the state" for programs such as Medicaid and Medicare.

Dr. Redwine is past president of the Woodbury County Medical Society.

IMS battles group B strep mandate

Friday, March 22 was the second major funnel deadline when most bills must have been passed by one house and approved by a committee in the other house to remain alive for the session. Tax, spending and leadership sponsored bills are exempt from the deadline. Adjournment is expected in mid-April.

Following is a summary of the status of key bills the IMS has worked on this year.

Group B Strep—HF 2182

The House went home for the week without voting on HF 2182, the group B strep bill, which means it is dead for the session; however, similar amendments could be attached to other bills before final adjournment.

One of the major issues of the legislative session for the IMS, HF 2182 would put into Iowa law a "standard of practice protocol" for screening for group B streptococcus. Based on a portion of a yet to be published consensus statement from the Centers For Disease Control and Prevention, the bill would require physicians to screen all pregnant women for group B strep between the 35th and 37th weeks of pregnancy.

The IMS strongly opposes putting medical protocols in Iowa law, particularly when there is no consensus on a "right" answer and accepted practice is continually changing as new information becomes available. Putting medical protocols in the Code will ultimately harm patients by limiting the ability of physicians to provide care based on the individual patient's needs.

The legislature is not the best forum for development of a standard of care. The IMS believes that while death of a child or other

AT A GLANCE

As of press time, Kiplinger Newsletter *said Bob Dole will be the Republican presidential nominee. Most experts predict a close election — much closer than the polls now indicate. Though some party pros wish he would, Pat Buchanan will not go away. Based on his support during the primaries, party insiders are forced to keep him aboard.*

In early March, a federal appeals court struck down Washington state's ban on assisted suicide, a law which is similar to one passed by the 1996 Iowa Legislature. The court issuing the ruling does not have jurisdiction in Iowa. However, Iowa lawmakers predicted the issue will ultimately come before the U.S. Supreme Court because so many states have passed similar laws.

Contacting your legislators

Telephone numbers during the session:

Senators	**515/281-3371**
Representatives	**515/281-3221**
Governor	**515/281-5211**

Write to them at:
STATEHOUSE
Des Moines, Iowa 50319

You may also contact your legislators at home when the legislature is not in session. If you don't know who your legislator is or need your legislator's home address and phone number, call Cheryl Peers of the IMS staff, 800/747-3070 or 515/223-1401.

loved one is tragic, HF 2182 is not a solution to prevent such deaths.

IMS lobbyists report that efforts made by individual physicians educating their legislators made the big difference in the outcome of this bill. All those who made phone calls, wrote letters, lobbied at the Statehouse, organized meetings with legislators or who wrote letters for distribution to the House of Representatives deserve recognition for their important contribution. This bill would not have passed without your help.

Statute of Limitations for Minors—HF 394

A major priority of the IMS this year is to reduce Iowa's extended statute of limitations for minors in medical malpractice cases. Current law provides that a lawsuit may be brought for an alleged birth injury until the child reaches age 19. At that time the normal statute of limitations is in effect. HF 394 provides that the normal statute of limitations would begin running at age 6.

HF 394 passed the House in 1995 but died in the Senate Judiciary Committee when Senator Tom Vilsack, a trail lawyer, threatened to keep the committee members there for hours discussing amendments.

Maternity Care

Legislators continue to struggle with the issue of health benefit coverage for maternity care. The House and Senate have passed different bills to address the issue. The issue will probably go to a conference committee.

The Senate bill, SF 2162, provides that third party payers must cover care recommended by the attending physician when following the most recent Guidelines for Perinatal Care as approved by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics.

The House bill, HF 2369, specifies that coverage must be provided for 48 hours after a vaginal delivery or 96 hours following a C-section.

Any Willing Provider/Direct Access to Care

Several "any willing provider" and "direct access" bills are under discussion by the legislature. Several bills have been introduced by limited license practitioners including chiropractors and optometrists who wish to ensure their place in managed care plans through legislation. Bills prohibit plans from requiring physician gatekeepers for limited license practitioners and prohibit MDs from serving as gatekeepers for DOs and vice versa.

HF 2298 and SF 2389, the direct access to chiropractors bills, remain on both the House and Senate calendars but neither has been brought to a vote.

The IMS continues to oppose these kinds of mandates. Such mandates only apply to the portion of health care benefit coverage regulated by the state; they do not apply to self-insured employers regulated by the federal ERISA law. (The IMS estimates that about 50% of employer-provided coverage is ERISA-regulated, 25% is Medicare and Medicaid, and the remaining 25% is state-regulated health benefits.)

The IMS is continuing to work with the business and payer communities to try to resolve such issues as patient access to physicians, due process and gag rules within managed care.

Dentistry Scope of Practice—HF 2201

HF 2201, which would allow the Board of Dental Examiners to define the scope of practice of dentists, was reported out of the Senate State Government Committee March 22. The IMS is concerned that the bill as drafted would allow the Board of Dental Examiners to declare reconstructive surgery to be within the scope of practice of dentists. Dentists claim that the intent is to fix a minor problem in their practice act.

The IMS will work with plastic surgeons and otolaryngologists to see if there is a way to fix the problem without expanding the scope of practice.

Assisted Suicide—SF 2066

The legislature has approved and the governor has signed SF 2066 providing for criminal penalties for assisted suicide. The bill contains language making clear that the penalties do not apply to physicians managing the pain of dying patients.

The IMS worked extensively on the bill to ensure that it would not interfere with the practice of medicine and supported the version that passed. IM

Medical Economics

Coding initiative causes big problems

Numerous calls are being received at IMS headquarters from Iowa physicians experiencing Medicare claim denials based on HCFA's correct coding initiative. The IMS and AMA are working closely with HCFA officials in an attempt to address difficulties being experienced by physicians and, as of press time, developments were occurring daily.

What is it?

In mid-1994, HCFA contracted with AdminaStar, an Indiana based Medicare carrier, to develop code edit software that could be used by all Medicare contractors.

The coding edits were designed so Medicare could detect unbundling or splitting of CPT codes when claims are submitted. *(For example, the edits would assure that Medicare would not pay for services that should have been included in a more comprehensive code, i.e. a rhythm strip if the physician is also billing for an EKG.)*

Congress liked it; AMA urged delay

In May, 1995, Sen. Tom Harkin received a report that said over $650 million Medicare dollars could be saved each year if HCFA used code editing software. To members of Congress anxious to save money in the Medicare program without reducing benefits to seniors during an election year, the report outlined what appeared to be easy savings.

In the report, the General Accounting Office (GAO) argued that similar software is being widely used by CHAMPUS, private payers and various state Medicaid programs.

HCFA argued against the use of existing and tested software because they had already signed a contract with AdminaStar for Medicare-specific software. The AMA protested use of such coding software, contending that physicians — not a computer — should choose correct codes.

After several months of false starts, AdminaStar sought the AMA's assistance in coordinating specialty society review of the thousands of possible coding combinations.

The AMA and 50 specialties told HCFA there were big problems with the coding edits and asked that implementation be delayed until the complete listing of revised coding combinations could be adequately reviewed and to allow time for educating physicians. HCFA refused to delay implementation.

Don't buy the manual

By November, AdminaStar had developed a package of 83,000 coding combinations which it implemented January 1, 1996.

Since then, AMA and IMS have received numerous calls and letters from physicians who are receiving claim denials and don't understand the correct coding initiative.

The physician community is being advised by Medicare carriers to purchase a voluminous (2,200-page) and expensive ($190) Correct Coding Manual from the National Technical Information Service, a for-profit branch of the Commerce Department. The manual contains the 83,000 coding edits.

AT A GLANCE

The median medical malpractice jury award in the U.S. rose to $500,000 in 1995 — 40% higher than last year, according to a private research group. The number of $1 million jury awards also increased, with 35% of awards hitting that level in 1995 compared with 27% in 1994.

Attorneys general of 26 states petitioned the Supreme Court to overturn a controversial ruling in an antitrust case that pits a Wisconsin Blues Plan against the 400-physician Marshfield Clinic. The state officials argue that allowing the ruling to stand could cripple antitrust enforcement.

So-called "safe harbors" from anti-kickback laws are so narrow they'll be of little or no value to most physician-sponsored plans, experts say.

PLEASE SEND US YOUR DENIAL EXAMPLES!

This article was written by Barbara Cannon, IMS director of medical economics. Ms. Cannon is working closely with AMA and HCFA staff on this issue and is collecting examples of coding denials from Iowa physicians. Call her at 800/747-3070 if you have experienced problems with HCFA's correct coding initiative.

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Specialty Coding Extravaganza II

"You Asked for It! We Have It!"

Date: Tuesday, April 30
Wednesday, May 1
Thursday, May 2, 1996

Where: Best Western Des Moines International
1810 Army Post Road
Des Moines

Based on the positive response from our 1995 Specialty Coding Extravaganza we are providing another opportunity to "ask the experts" at the 1996 Specialty Coding Extravaganza II! We have three experts in the coding profession to provide the most up-to-date, useful coding information for your specialty. Each expert session will focus only on one specialty. You will be provided time to ask questions, discuss coding procedures and find ways to resolve problems that you encounter in your practice.

You will not want to miss this opportunity to get answers from professionals who work with the specialty coding issues, have researched problem areas and have the keys to successful coding.

SURGERY CODING—TUESDAY, APRIL 30, 1996—8:30 A.M. TO 4:30 P.M.—TERRACE ROOM 4
NANCY MAGUIRE, THE NANCY MAGUIRE ACADEMY

This full day will provide general surgery coding techniques that will include orthopaedic, neurosurgery and ENT. Nancy was a featured speaker at our 1995 Coding Extravaganza. She has 20 years of experience in the medical field which also includes being a nurse and x-ray technician. Nancy is a national seminar speaker with vast knowledge and enthusiasm for coding issues.

PEDIATRIC CODING—TUESDAY, APRIL 30, 1996—1:00 TO 4:30 P.M.—TERRACE ROOMS 2 & 3
MIKE REILING, PARTNERS CONSULTING GROUP, LTD.

This afternoon half-day session will provide coding and billing guidance on all aspects of pediatric practice. Mike has provided coding expertise for many Iowa single and multispecialty groups and is a frequent co-presenter at Iowa Medical Society workshops. (This will not duplicate the primary care workshop Mike will be presenting on Wednesday.)

PRIMARY CARE CODING—WEDNESDAY, MAY 1, 1996—8:30 A.M. TO 4:30 P.M.—TERRACE ROOM 4
MIKE REILING, PARTNERS CONSULTING GROUP, LTD.

This full-day program will provide a focus on primary care coding concerns and practical suggestions to avoid reimbursement risk. Mike will discuss E & M vs. preventative codes, chart documentation practices, correct use of modifiers, coding for procedures vs. services and using add-on service codes.

OBSTETRICS & GYNECOLOGY—THURSDAY, MAY 2, 1996—8:30 A.M. TO 4:30 P.M.—TERRACE ROOM 4
JACQUELINE LEOPOLD, PRACTICE MANAGEMENT CONSULTING CORP.

By request, Jacqueline Leopold, a nationally known speaker on OB/GYN coding, will present a full-day program. Jacque is a popular and well-received educator who brings 20 years of experience in the health care policy arena. Jacque will focus on the variety of coding issues unique to OB/GYN practices including hospital services, office services, procedures and global packages.

REGISTRATION FORM ON THE REVERSE SIDE

COST: **$99 per day/participant prior to April 15 ($119 after April 15)**
$49 per half-day/participant prior to April 15 ($69 after April 15)

The cost of the full day seminar includes break refreshments and lunch. Half-day does not include lunch. Be sure to bring your own ICD9•CM books and 1996 CPT book.

NOTE: Discount, credits or coupons cannot be used for the **Extravaganza**.

For hotel reservations call the Best Western Des Moines International at 515/287-6464. Be sure to mention the seminar name for special rates. Maps are available upon request from Sherry Johnson at the IMS, 800/728-5398 or 515/223-1401.

Registration Form

Specialty Coding Extravaganza II

Name: _____

Clinic/Practice Name: _____

Address: _____

Phone: _____ Fax: _____

Specialty Session: _____Surgery _____Peds _____ Primary Care _____OB/GYN

Amount Enclosed: _____ Date: _____

Please make checks payable to IMS Services. Mail check and registration form to:
IMS Services, ATTN: Sherry Johnson
1001 Grand Avenue, West Des Moines, IA 50265-3599

Registration Form

Specialty Coding Extravaganza II

Name: _____

Clinic/Practice Name: _____

Address: _____

Phone: _____ Fax: _____

Specialty Session: _____Surgery _____Peds _____ Primary Care _____OB/GYN

Amount Enclosed: _____ Date: _____

Please make checks payable to IMS Services. Mail check and registration form to:
IMS Services, ATTN: Sherry Johnson
1001 Grand Avenue, West Des Moines, IA 50265-3599

Some physicians took this advice and purchased the manual. AMA and IMS are now receiving complaints from physicians and their staff that the manual is: a) too expensive; and b) so poorly written and formatted that it is completely useless. In addition, the manual is already out of date.

Iowa physicians report common problems

There were over 2,200 claim denials in Iowa in January. Family physicians and internists have experienced the greatest number of denials. According to IMS staff and communications received from the AMA, the coding initiative is causing the following common problems:

- Medicare in Iowa will deny claims for lack of correct coding, but will not tell physicians why their claim was incorrectly coded.
- Non-participating physicians are in violation of Medicare's limiting charge provisions. This means their patients are notified that their doctor billed in error and owes them a refund.
- Medicare is denying an E & M code for an office visit if a pap smear is collected during the encounter. As a result, many Iowa physicians have stopped billing for the pap smear collection even though they continue to provide the service.
- A chest x-ray and rib x-ray done on the same day will be bundled and only one paid.
- A hammertoe procedure and bunionectomy will be bundled and only one procedure paid.

How to respond to a coding denial

IMS and AMA advise physicians who have received coding denials to:

- Be sure you are using the appropriate codes and modifiers. Extreme caution is advised in using the GB modifier which can be used to indicate distinct procedures or distinct services.
- Ask specifically if the coding edit is still in place. It is possible HCFA has removed it due to input by specialty societies to AdminaStar. If not, send an example to your national specialty society and the IMS.
- Maintain a file of involved claims. HCFA has committed to automatically reprocess claims found to be denied in error. You will need records to validate this action.
- Check with the IMS to determine whether concerns over a particular code edit have been raised with AdminaStar.

What's ahead

The AMA has proposed and HCFA has agreed to use the recently formed AMA Correct Coding Policy Committee as a dispute resolution vehicle to receive input from the AMA and specialty societies and make recommendations to AdminaStar.

The committee will serve a vital role in advocating the best interests of the medical profession on the correct coding issue. The committee will review suggestions on more than 850 coding combinations which AdminaStar withdrew from Phase I when it was implemented in January.

The same committee will provide input to Phase II of the AdminaStar contract. Phase II will include 16,000 additional coding combinations for implementation during the latter half of 1996. HCFA does not wish to delay implementation of Phase II due to pressure from Congress. IM

There were over 2,200 claim denials for Iowa physicians in January.

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CHMIS Update

Physician representatives on the CHMIS Governing Board:

Dale Andringa, MD
Des Moines
515/241-4102

Beth Bruening, MD
Sioux City
712/233-1529

IMS CHMIS Committee:

Terrence Briggs, MD (chair)

IMS staff:
Barb Cannon
Ed Whitver
Dean Gillaspey

The CHMIS Governing Board has accepted the recommendations of a special task force, setting the stage for a new conceptual model for CHMIS.

The Governing Board will look to its Executive Committee for recommendations on specific issues to complete the model. Since this is a new beginning for CHMIS, it is very important for physicians to continue to monitor the process and provide input.

Key provisions of the new model are:

- There will be no centralized data repository. However, the Governing Board believes there is a need for public access to health care data. Therefore, CHMIS will access proprietary data bases (such as those of insurance companies, health systems, etc.) in order to generate public interest reports. This data will be stored at the Iowa CHMIS and available for analysis.
- Physicians will not be required to submit insurance claims electronically or contract with an electronic data interchange (EDI) network. The CHMIS Governing Board will continue to encourage various electronic transactions as a way to lower health care administrative costs.
- CHMIS will facilitate setting of standards for electronic claims submission, eligibility, remittance advice, claims status inquiry and supplemental information.

The law establishing CHMIS gives the Governing Board authority to require providers, payers and EDI networks to develop file formats, field contents and time frames for implementing electronic transaction standards. However, the Governing Board prefers that all stakeholders participate voluntarily in this process.

- CHMIS Oversight (and authority to fine) will stay with the Insurance Division.
- Only the Ethics and Confidentiality Advisory Committee will remain in place. The other committees will be replaced by a Standards Advisory Committee and a Data Analysis/Reporting Advisory Committee. Anyone interested in serving on the new advisory committees may contact Ed Whitver of the IMS staff, 515/223-1401 or 800/747-3070. IM



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Practice Management

MGMA audit worksheet

If you are using the MGMA "E & M Documentation Auditors Worksheet" for internal reviews, be especially careful in two areas.

In Section II, PHYSICAL EXAM, note that only organ systems (not body areas) count in the audit scoring. In Section V, LEVEL OF SERVICE, note that certain eodes require 3 of 3 key eomponents while others require 2 of 3 key eomponents. For questions on ordering or using the worksheet, call Barb Cannon at the IMS, 515/223-1401 or 800/747-3070.

Specialty-specific physical exam criteria

IMS has just completed 15 seminars for over 800 attendees receiving HCFA's audit format for Evaluation & Management (E & M) code documentation. One frequent question deals with the requirements for a comprehensive physieal exam. To date, specialty speeific physical exam criteria have not been released by HCFA. IMS recently contacted the Medicare B carrier in Iowa. They reaffirm and stand by their position of requiring documentation which shows examination of eight or more orgàn systems to substantiate a comprehensive physical exam. They will make no exceptions for specialty specific criteria until they are published by HCFA.

If you have questions, call Barb Cannon at the IMS, 800/747-3070 or 515/223-1401.

CIGNA may want second opinion

CIGNA, the Medicare carrier for Durable Medical Equipment, is continuing efforts to eliminate fraud and abuse. Physicians should take note that the DME carrier may ask for a second opinion regarding whether an item is medically necessary. IM

AT A GLANCE

The number of health care workers dedicated primarily to paperwork has risen a whopping 693% since 1968, according to a recent issue of the American Journal of Public Health. *The number of doctors has increased by 77% and the number of nurses by 164%.*

The growing presence of powerful personal computers coupled with entrepreneurial spirit has led to a new educational opportunity — multimedia CME. Most of the new CME products depend on CD-ROM, a method of packaging data onto a compact disk. Through the disk, a computer with a sound board and speakers can serve as an electronic bookshelf and virtual classroom.

Don't miss the inserts in this month's Iowa Medicine *describing the latest practice management seminars available through IMS Services.*

MIDWEST MEDICAL INSURANCE COMPANY • FOCUS ON RISK MANAGEMENT

Physicians spend average of one minute educating patients

How much time do you spend edueating patients? In one study, physicians were asked to estimate the amount of time in a medical interview spent on education. On average, the physicians responded that they spend seven to 10 minutes teaching their patients. The researchers then audiotaped the same physicians and analyzed dozens of physician-patient interviews to determine how much time was actually spent on patient education. The result? One minute, on average, was spent educating patients.

Even when more time is spent, patients may forget a considerable amount of the information provided to them by their physician and other health care professionals. Patient injuries and malpractice claims can result from patient misunderstandings and failure to follow the treatment plan. One study revealed that the lack of information about their prescription drug was the main reason 30-50% of patients did not follow their medication regimen.

Reduce your liability risks by:

•Educating patients about their treatment options, any tests to be done and follow-up required. Avoid using medical jargon and assess the patient's level of understanding.

•Providing written material available from many specialty societies and disease-related organizations to supplement verbal education and instruetions. Evidence shows written materials improve comprehension and retention.

•Involving family members — with the patient's consent — in the education process.

•Documenting your education efforts in the medical record.

For further information, contact Lori Atkinson, MMIC risk management supervisor, MMIC West Des Moines office, PO Box 65790, West Des Moines, Iowa 50265, 800/798-9870 or 515/223-1482.

The Richard M. Caplan Chair in Biomedical Ethics and Medical Humanities

To honor Dr. Richard Caplan for more than three decades of service, his colleagues, friends, and former students have initiated a campaign to establish the Richard M. Caplan Chair in Biomedical Ethics and Medical Humanities in the University of Iowa College of Medicine.

Since joining the faculty of the UI Department of Dermatology, Dr. Caplan has become known for his work with Iowa's Program in Biomedical Ethics and Medical Humanities and in continuing medical education. Iowa physicians also know Dr. Caplan from his service to the Iowa Medical Society and his essays in the *Journal of the Iowa Medical Society/Iowa Medicine.*

This campaign will help ensure the continued excellence of the Program in Biomedical Ethics and Medical Humanities and serve as a lasting tribute to Dr. Caplan. UI alumni and friends will receive information this spring about how to support the Richard M. Caplan Chair.

"In mature and ideal physicians the information, problem-solving, and service they provide are augmented by wisdom and compassion."

Dr. Richard M. Caplan,
Journal of the Iowa Medical Society,
November 1973



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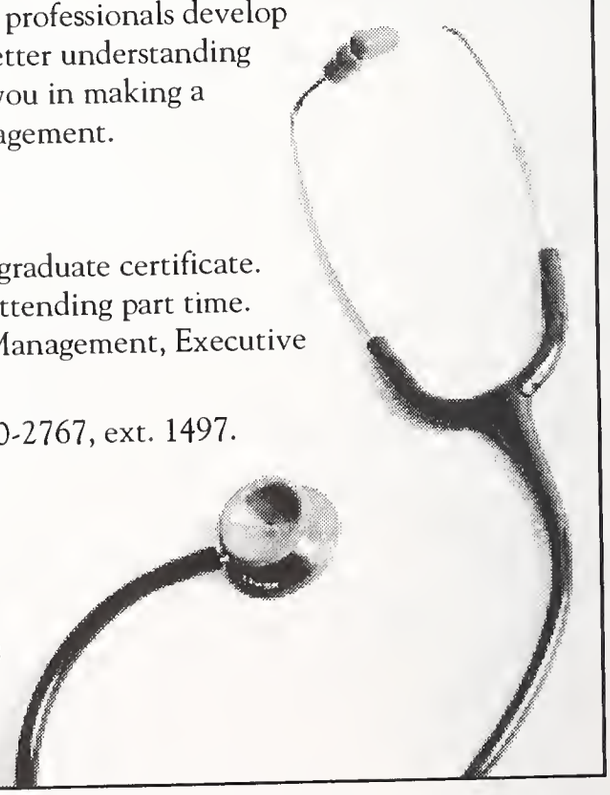
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Newsmakers

Prostate cancer treatment article incomplete

Letter to the Editor

Dear Editor:

I recently read the article entitled "Prostate cancer management in older patients" (December *Iowa Medicine*). Since the contributing authors of the Iowa Prostate Cancer Cooperative Project are urologists, radiation oncologists and medical oncologists and the introductory paragraph suggests the article will comment on patterns of care, I was hopeful for a thorough discussion of all relevant treatment options for prostate cancer. Instead, the entire focus of the article was on the use of radical prostatectomy in men older than 75.

Although the study was interesting, it hardly addresses the current controversies in the treatment of prostate cancer. No mention was made of radiation therapy (probably the most common therapy for prostate cancer in men over 70), hormonal manipulation or close observation. Nor does the article comment on the adequaey or appropriateness of the surgical choice, but simply lists the rates at which the surgery is done in Iowa hospitals. Finally, the author doesn't give his opinion as to whether radical prostatectomy is an appropriate choice in this patient group.

Just because radical prostatectomies can be done in elderly men doesn't necessarily mean they should be done. I hope this is just the first in a series of articles by this Cooperative Project and that each of these other treatment options are covered as well. Those of us in community practice look to teaching institutions and multidisciplinary cooperative groups for anwers and recommendations regarding the best care for our patients and we need broad-based information. —*Cassandra Foens, MD, co-director, radiation oncology, Covenant Cancer Treatment Center, Waterloo.*

UI College of Medicine news

Dr. Susan Johnson, UI College of Medicine professor of obstetries and gynecology and associate dean for faculty affairs, is one of 25 women from academic medical centers across the nation appointed as 1995 fellows of the Executive Leadership in Academic Medicine (ELAM) Program for Women. ELAM is a national program that helps prepare women faculty in academic medicine for senior leadership positions. **Dr. William Erkonen,** UI assistant professor of radiology, has been named a fellow of the American College of Radiology. Dr. Erkonen was also appointed to the editorial board of the Radiological Society of North America Learning Center. **Dr. Kevin Dellsperger,** UI associate professor of internal medicine, has been appointed to the editorial board of the *American Journal of Physiology: Heart and Circulatory Physiology.* **Dr. Antonio Damasio,** UI professor and head of neurology, has been elected to the Institute of Medicine of the National Academy of Sciences, one of the highest honors in the world of science and medicine. **Dr. Elvira Lang,** UI associate professor of radiology, has been elected a fellow in the Society of Cardiovascular and Interventional Radiology. **Dr. James Merchant,** UI professor of preventive medicine and environmental health and internal medicine, has been appointed to a four-year term as chairman of the board of Scientific Counselors for the National Institute for Occupational Safety and Health. **Dr. Marianette Miller-Meeks,** UI assistant professor of ophthalmology, has been awarded the 1995 Charles Phelps Memorial Award, which is given in memory of Dr. Phelps, former head of the UI Department of Ophthalmology, who died one year after his appointment. **Dr. William Standford,** UI professor of radiology, has been appointed to the board of directors of the North American Society of Cardiac Imaging. **Dr. Michael Welsh,** UI profes-

continued

AT A GLANCE

A campaign is under way to endow the Richard Caplan Chair in Biomedical Ethics and Medical Humanities in the UI College of Medicine. The Caplan Chair will enable the college to support the work of nationally recognized faculty members in biomedical ethics and medical humanities. Dr. Caplan has been with the UI for over 30 years.

Burgess Memorial Hospital, Onawa, has been named one of the top 100 hospitals in the country by HCIA, Inc., a health care information company and William M. Mercer, Inc., a human resource consulting firm. The news was published in an article in Modern Healthcare. *Hospitals were listed in five categories with the top 20 in each category. Burgess is in the top 20 rural hospitals with fewer than 250 beds.*

Newsmakers

continued

sor of internal medicine, has been named president-elect of the American Society for Clinical Investigation. **Dr. Frederick Blodi**, UI professor emeritus of ophthalmology, has been awarded honorary membership in the American Ophthalmological Society.

New members

Dubuque
Michael Chapman, MD, orthopedics
Daniel Fabiano, MD, orthopedic surgery
Joseph Fuller, MD, general surgery
Mitchell Manthey, MD, gastroenterology
Kim Riess-Sagers, MD, nephrology
Nicholas Stanek, MD, neurology

Iowa City
Marguerite Oetting, MD, pediatrics
Frederick Ovrom, MD, internal medicine
Kelly Skelly, MD, family practice

Summer
Danilo Ruiz, MD, general surgery

Urbandale
Holly Healey, DO, family practice
Kelly Reed, DO, family practice

West Burlington
Tracy Bell, MD, family practice

Williamsburg
Timothy Murphy, MD, family practice

Deceased members

Niels Hansen, MD, 100, general practice, Mercer Island, Washington, died February 7

Joseph Prior, DO, 78, life member, anesthesiology, Davenport, died February 11

Carlton VanNatta, MD, 79, family practice, Des Moines, died February 15 IM

'Whizzing and a fractured humerous'

The following was contributed by Sandra Shultice, a dietician with St. Luke's Hospital in Cedar Rapids. She writes:

Dear Editor . . . I am aware that there is a campaign under way to foster more scholarly and precise medical documentation. In light thereof, I am submitting the enclosed for your amusement. All of the blunders were actually noted within our system. Some are attributable directly to physicians; many to ward clerks, nurses, transcriptionists and, inevitably, the computer.

Mind Your Ps and Qs

Dietitians, as they go about stamping out obesity and malnutrition, are scanning charts for absurdities, misspellings and typographical errors. The following description of a fictitious patient is a composite of their finds.

Mrs. Zilch, an unfortunate elderly female, was admitted with complicated renal calculated disease, whizzing, a fractured humerous and fever of unknown ideology.

Her memory for recent events was very fussy. She did not know the memories of her family. She exibited acute hepatic encephalopathy despite a normal pneumonia level. She denied use of ethanol or tobasco.

A videopharyngogram was done to evalute her swallowing ability and it was deemed she would benefit from femoral stimulation.

A caloric count was ordered. She ate a small bowel of soup for lunch and 100% of her H.S. snake.

She has been on Lasix under her family doctor's duration, but she has not seen him in a long time.

Her staff infection was treated with oreomycin, but it did not make her feel grammatically better.

She died at 103 of declining health.

Emergency Physician Practice Opportunity

Dubuque Emergency Physicians, P.C. *is a 4-member group practice that has provided 11-years of care at Mercy Health Center, Dubuque, Iowa. Mercy Health Center, St. Joseph's Unit at Dubuque is a 410-bed medical center that services a tri-state area. We are seeking a BC/BP Emergency trained physician or a boarded physician with extensive emergency experience for a full-time position. Become the fifth member of our team in a modern ED with 23,000 annual visits and weekend double coverage. This position offers exceptional compensation and benefits, plus a short time to partnership. Dubuque, Iowa is a family oriented community located on the scenic Mississippi River. You will enjoy a lifestyle unsurpassed by any other region in the country. Dubuque, Iowa offers a matchless public and parochial school system, a strong and growing economic base, and ample recreational and cultural activities.*



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More time with community physicians

Out of the Classroom

Educational focus for medical students at the University of Iowa is shifting from the classroom to the bedside and the clinic. With the advent of the new curriculum, students will get earlier exposure to a medical practice and spend more time with community physicians.

Medical education at the University of Iowa today is a far cry from the late 1870s, when apprenticeships were the focus of training and a medical degree could be earned with little more than two years of classroom lectures and a smattering of laboratory experience. As the field has grown more sophisticated, the educational focus has shifted from classroom lectures to more hands-on experience in the laboratory, at the bedside and in the clinic.

More time with community physicians

With the institution of the new UI medical curriculum, students will spend a bigger chunk of their hands-on training with community physicians around the state.

"From early experience shadowing health care providers, to the family practice preceptorship and the new third-year core clerkship in community medicine, students are getting the opportunity right away to learn first-hand how a practicing physician cares for patients and functions in the community," says Dr. Jerold Woodhead, UI associate professor of pediatrics and curriculum director for the third-year generalist core.

Students will spend a bigger chunk of their training with community physicians around the state.

Not a new idea

The push to expose medical students to community medicine is not new.

"The idea that medical students can learn all they need about patient care from hospital-based inpatient rounds has been criticized for decades," Woodhead adds.

The move toward training more generalist physicians also plays a role in increased community training for students.

"It's based on the premise that spending time in a community and becoming familiar with the medical practice and lifestyle of a generalist will help attract students into primary care disciplines," he says.

This is not to say that providing students with the chance to spend time with practicing physicians is a new concept at Iowa. Since the Department of Family Practice was established in 1970, third-year medical students have worked with preceptors around the state during the three-week required preceptorship in family practice. Today, 140

Vera Dordick
Ms. Dordick is assistant director of Health Science Relations at the University of Iowa.

of Iowa's board certified family physicians play a role in educating UI medical students. Spending time outside of a tertiary care center allows students to see a different side of medical practice.

Getting exposed to the real world

"It's a chance to expose them to family practice in a real world and experience the fun we're having," says Dr. Kim Brandt, a Mount Vernon physician who serves as a preceptor in the program. "It helps to learn from the books if you have something from real life to go on."

The Medical Education-Community Orientation Program (MECO) has also been giving students an entree into eommunity physician offices since 1970.

More than 1,200 students have participated in the optional program, which takes place in the summer between the first and second years of medical school. Students spend 4-12 weeks with a practitioner working and learning.

With the advent of the new curriculum, MECO will no longer be a student's first exposure to a medical praetiee.

Beginning this spring, first-year medical students will spend two afternoons during the semester shadowing practicing physicians and other health care providers — nurse practitioners, physician assistants and counselors.

"The aim is to introduce first-year students to ambulatory patient eare settings and give them experiences that reinforce material in the basic science courses," says Dr. Eric Evans, assistant professor of family practice and curriculum codirector for the Foundations of Clinical Practice course.

"During the second semester, students will learn how to do some parts of the physical exam and history so the shadowing program will allow them to observe experienced clinieians practicing medicine."

Students better prepared for clerkships

"We think MECO instructors may see a difference among the students who participate in the program during the summer of 1996. The next group of participants will have shadowed health care providers and should be better prepared," he says.

Because of this early experience, students should also be better prepared for the clinical clerkships after the second year of medical school.

The exposure brings clinical relevanee to medical education at an earlier stage. Medical students will also be better prepared for the required six-week eommunity clerkship in the new third-year curriculum.

The overhauled plan for the clinical years of medical education calls for students to take core courses in the primary care disciplines.

"The core courses provide a foundation of clinical experience and patient interaction that prepares the student to sample other fields," Woodhead says. "Spending time with community doctors is an integral part of this core clerkship experience. Students need to learn how generalists practice and how they allocate time to self-directed continuous learning — something the new curriculum stresses," he adds.

"The aim is to introduce first-year students to ambulatory patient care settings."

Great wave of change

"Medicine and the environment in which it is practiced is changing more rapidly than anyone imagined possible," Woodhead says.

This great wave of ehange presents challenges for finding the best ways of educating tomorrow's physicians. While medical education today doesn't quite hark baek to the old apprenticeship days, it increasingly draws upon old wisdom: experiencing medicine with practicing physicians is an undeniably important part of learning. IM

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In 1995, a special task force initiated a fund-raising campaign for the IMS Education Fund, which supports scientific and public health education and administers a medical student loan program. Since April 1995, a total of $121,445 has been contributed or pledged by the following physicians. Although we are unable to personally thank every contributor, we extend our heartfelt appreciation to all who have supported the activities of the IMS Education Fund. We hope you will continue to "give back to your profession".

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The Journal
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UI cancer research links laboratory, clinic

● C. LINDON LARSON

As the state's leading center for cancer research and treatment, the University of Iowa faces a dual challenge: pursuing new knowledge while providing advanced clinical services in a changing environment.

"We have a mandate to bring the latest research to Iowans in the context of high-quality clinical care," says Dr. Robert Wallace, director of the Cancer Center at the UI College of Medieine. Together with the comprehensive treatment programs of the UI's Pappajohn Clinical Cancer Center, the College battles cancer in the laboratory, the clinic and the community.

Exploring the cell's workings

"Our basic researeh includes looking at why cells reproduce, the genetic mechanisms of cell reproduction and the various signaling pathways by whieh eells work," Wallace says.

Dr. Gary Koretzky, Kelting associate professor of rheumatology, is among the researehers addressing how cells receive messages that move them to action. "A eell perceives external surroundings through receptors on its surface that bind to molecules in the environment. We want to know how the cell nucleus receives information from these receptors and how different signaling pathways are integrated."

Koretzky's laboratory identifies and analyzes molecules that appear to be important in the signaling process. By creating mutant cells, he and his team ean assess how a missing or altered molecule affects signaling events and cell function.

"We're studying activation of cells and apotosis, or cell death, which is important for terminating responses," he explains. "Abnormalities in apotosis may be one factor in malignaneies."

Studying how cells respond to their environments may also provide information about immune functions, which play an important role in regulating malignancy. Dr. Arthur Krieg, UI associate professor of internal medicine, has found that particular types of DNA trigger immune responses. Using DNA or molecular signals to boost immunity may be a useful supplement to other cancer therapies.

Cancer Center research groups bring investigators with specialized interests together to approach common questions. "The program provides synergism among researchers," Koretzky says. "Very focused investigators can get insights from colleagues who have looked at problems differently."

Forging therapies from science

Dr. C. Patrick Burns, UI professor of internal medicine, leads a group looking at experimental therapeutics and oxidative events. "Most cancer treatment has focused on damaging or killing DNA in cancer cells. There's evidence that, in some cases, oxidation causes much of the damage to these cells," he says.

Understanding the role of oxidation in chemotherapy and modifying cancer cells to increase their susceptibility to oxidation may lead to more effective treatment. Human studies are addressing how omega 3 fatty acids may aid in cancer therapy.

"Some projects ask whether consuming fish oil fatty acids might make cancer drugs work better," Burns says. "It's also possible that they may help patients with terminal cancer feel better and fight cachexia."

Monoclonal antibody treatments are also

The IMS Education Fund has designated this article as the Henry Albert Presentation Award for April 1996.

C. LINDON LARSON
Mr. Larson is an associate editor for Health Science Relations at the University of Iowa.

UI cancer research links laboratory, clinic

continued

in clinical trials. The antibodies can zero in on cancer cells, providing a way to identify and attack these cells.

According to Dr. George Weiner, associate professor of internal medicine and associate director for education in the Cancer Center, monoclonal antibodies are not magic bullets. However, they continue to be refined into potentially promising treatments. "We now know how to genetically modify the antibodies to make them more effective and reduce side effects," Weiner says.

An antibody in trials for treating B cell lymphoma shows promise, Weiner says. "More than half of the patients seem to be responding with few side effects. This antibody eventually may be approved for sale."

Other research addresses the basics of cancer knowledge and clears new paths to treatment. Dr. Lubomir Turek, UI associate professor of pathology, leads projects in molecular and tumor virology, analyzing the carcinogenic potential of viruses. Dr. Beverly Davidson, UI assistant professor of internal medicine, studies the potential of gene therapy in treating certain cancers, particularly brain tumors. These projects may lead to full-scale treatment options.

Refining new treatments

"Our strengths in investigational therapies include urologic oncology, with ongoing initiatives for patients with advanced prostate cancer and both early and advanced bladder cancer," says Dr. Robert Dreicer, UI associate professor of internal medicine and urology and associate director of clinical research for the Cancer Center. "In neuro-oncology, we have several projects dealing with primary brain tumors, while gynecologic oncology researchers have novel studies under way in cervical and ovarian cancer."

Dreicer also points to collaborative projects in head and neck cancer, ocular melanoma and renal cell carcinoma as further evidence of the center's wide expertise. "In addition, our bone marrow transplantation group is pursuing investigational work to treat lymphoma and myeloma. They also have some very encouraging data for patients with advanced breast cancer," he says.

Advances in supportive care and collaboration across disciplines are beneficial developments, Dreicer says. "We will provide quicker ins and outs for patients where multiple consultations are done and joint planning is more pervasive," he says. "This will translate into better patient management and more efficiency."

Working with communities

Referring physicians play an important role in the care their patients receive from the UI, especially as more treatment options are made available in the community. "I think most of us would like to see both investigational and standard therapies provided as close to home as is practicable, which is happening in our outreach programs," Dreicer says.

As more care is offered at the community level, UI physicians will continue to see an increase in patients who have been heavily treated before referral. "Considering current trends in medicine, I expect to see more patients with advanced disease and this speaks to the expertise in the communities around us," Dreicer adds.

Collaboration with community physicians is essential to Cancer Center research. "Clinical trials rely on community cooperation and support," Weiner says. "Physicians should feel comfortable referring patients who may benefit from participation in trials. We work with referring physicians and do our best to arrange for much of their care to be given close to home."

Though cancer remains a scientific and clinical challenge, biomedical research has made invaluable discoveries at many levels. "I don't think we should expect to cure cancer in the next few years, but research is making progress toward greater knowledge and new treatments. Every year brings exciting discoveries," Burns says.

Institutions like the University of Iowa offer physicians the means to expand knowledge while providing the latest care. "I take care of patients with lymphoma and do basic work in the laboratory and I'm constantly linking the two areas," Weiner says. "That's what academic health centers are all about—having people who are able to bridge the gap between basic research and the clinical care of patients." IM

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A view from both sides of the fence

As physicians, it is often our unhappy task to inform patients and their families of serious illness or injury and the resulting consequences. It is part of our professional duty, but how do we function in these circumstances? Certainly our medical training does not address this question, except by way of observation of our tutors. Patients accept our verdicts and we go about our business of caring for the patient to the best of our abilities. Many physicians are very compassionate in such situations; others not so compassionate. Our profession has been criticized for being cold, indifferent and impersonal . . . poor "bed-side manners" if you wish to call it that. My plea is to the physician in training as well as the established practitioner: look to yourself. How do you relate to patients during times of strife, worry and concern?

Some of my readers have been on the receiving end of a "bad news" medical message. Others have no clue about what it is like to hear from an attending physician about a personal health tragedy. Recently, I was on the receiving end. Believe me it is very different from professional experiences I have had telling a family that their child was a victim of poliomyelitis (as often was the case in the 1950s), leukemia, cystic fibrosis or a malignancy. Having a knowledge of medicine does not make it easier to accept; perhaps less so.

Having a knowledge of medicine does not make it easier to accept.

Last October my wife awoke one morning unable to coordinate her right arm and leg. Her speech was garbled. Examinations and the MRI confirmed what I feared—she was a victim of a stroke. A short stay in the hospital and continued therapy fortunately led to nearly complete recovery. She (we) were most fortunate.

During the Christmas holidays another blow fell upon us. Our oldest daughter was a victim of a malignant brain tumor. As I viewed that shadow on the MRI I wanted to cry out as did Lady Macbeth "Out damn spot! Out I say!" Our greatest support came largely from our daughter's tremendous strength and faith. Surgery has been successful and now she faces a course of radiation. Time will determine what follows.

In both these experiences we were supported by physicians who were honest, compassionate, supportive and understanding. I do not suggest these physicians were exercising professional courtesy. They demonstrated a professionalism and caring which I hope others emulate.

I ask all in our profession to accept my plea—when you must impart information to patients and their families, put yourself in their shoes. Take time to explain the situation in lay terms and answer questions. Ongoing rapport will engender trust and foster a strength of faith that is so important at a difficult time. IM



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Iowa Medicine

JOURNAL OF THE IOWA MEDICAL SOCIETY | MAY–JUNE 1996

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REC'D NOT IN CIRC.

Central Iowa group is positioned for the future (first in a series)

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1996 Iowa Legislature a challenge for IMS

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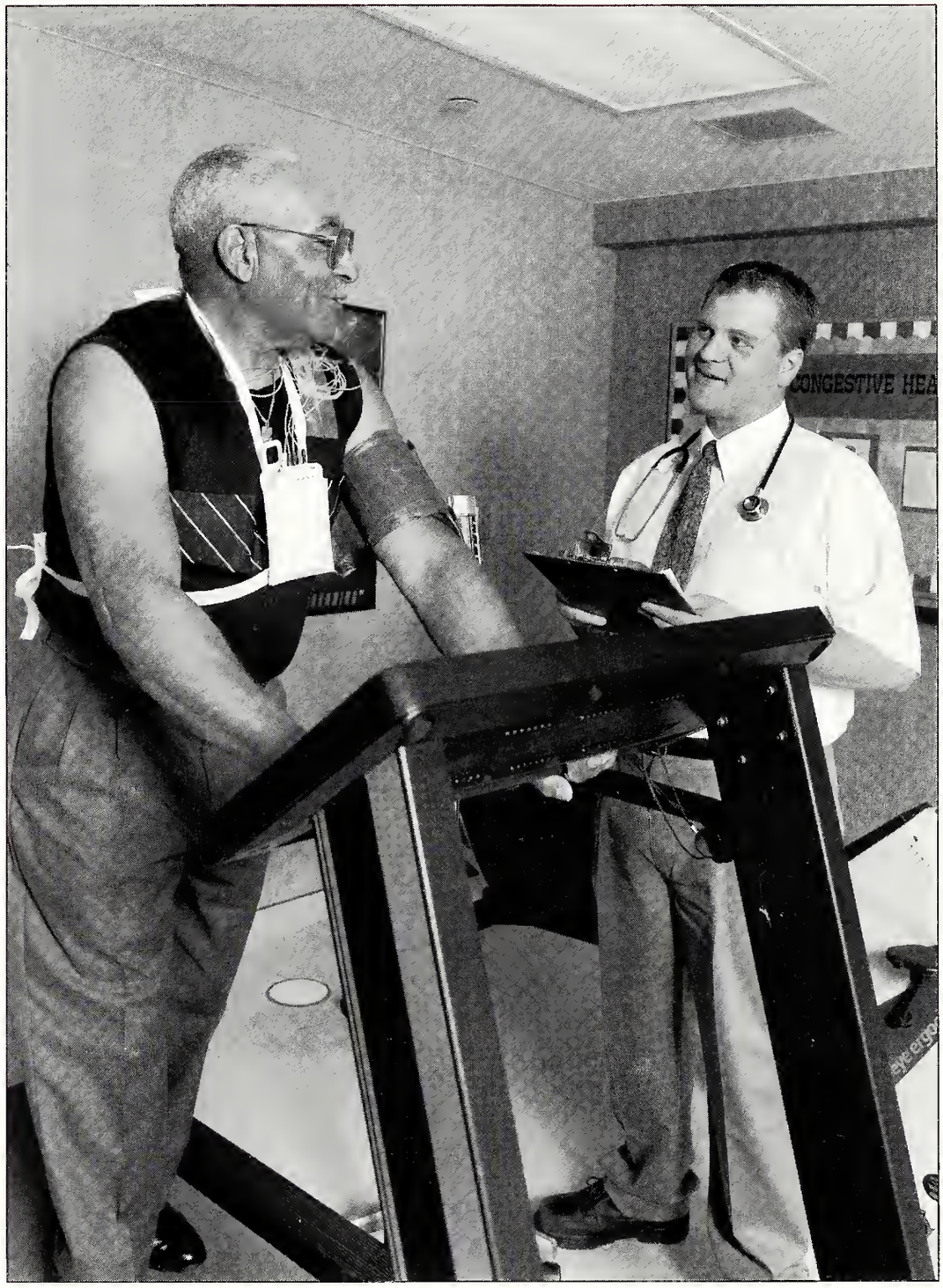
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IMS *DEADLINE* news

MAY-JUNE, 1996

Late-breaking news of interest to Iowa physicians

●**DON'T FORGET THIS IS THE FIRST MONTH** of the new *Iowa Medicine* publishing schedule. This issue — the May/June issue — will be followed by the July/August issue, which will be mailed the first week of July. You will receive a one-page newsletter in June and August.

●**AS OF PRESS TIME, THE IOWA LEGISLATURE** was still in session, arguing over budget matters in a state-level reenactment of the protracted Congressional battle. Legislators' expense money ran out April 16 but at this writing they were promising to return on Monday, April 29 and stay at least another week. Read a wrap-up of the fate of most bills of interest to Iowa physicians in this month's Legislative Affairs section, page 188.

●**THE KENNEDY-KASSEBAUM BILL** passed the Senate 100-0 on April 23. The bill assures portability of health insurance and eliminates discrimination based on pre-existing conditions. The AMA estimates that as many as 25 million people would benefit from reforms that would guarantee they would not lose their coverage as they move from job to job. AMA President Lonnie Bristow applauded the U.S. Senate but expressed disappointment that medical savings account provisions were not included in the bill. Sen. Bob Dole has indicated he will press for inclusion of MSAs in the final bill that reconciles differences between the House and Senate versions of health insurance reform.

●**ELDON HUSTON, EXECUTIVE VICE PRESIDENT OF THE IMS,** announced at the April 20 IMS House of Delegates meeting that he will retire at the end of 1996. The Board of Trustees presented an informational report to the House of Delegates regarding the process they intend to follow in hiring a new EVP. The Board will work with a search firm and is in the process of gathering input from IMS leadership, specialty society officers and others.

●**A MEMBER PHYSICIAN CALLED IMS HEADQUARTERS** with an interesting tale. It seems he received a contract from a health care network that would have paid him 120% of the RBRVS fee schedule. He waited to sign and eventually received a call from the company. When he told the company representative he didn't like the proposal for the fee schedule, they offered him 135% of the RBRVS. "Do physicians know they can negotiate these fees?" he wondered. We told him we'd pass along his story. (NOTE: IMS does not recommend accepting fee schedules tied to percentages of Medicare fees; fees are better tied to the RBRVS and a dollar conversion factor.)

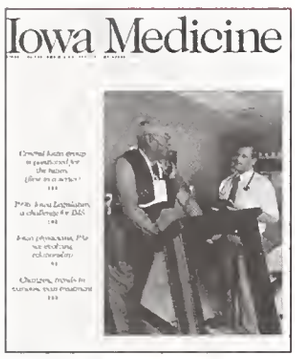
●**RESOLUTIONS ON POINT-OF-SERVICE FEATURES** in managed care plans and other managed care issues were much-discussed by the IMS House of Delegates at its annual meeting April 21. Check the July/August *Iowa Medicine* for more details on actions taken by delegates.

●**UPDATE ON MEDICARE'S "CORRECT CODING"**. . . Due to efforts by the IMS, the AMA and others, HCFA has changed the Correct Coding Initiative AdminaStar edit involving the collection code for pap smears, which has caused problems for Iowa physicians. Effective immediately, the office visit code will be paid and the pap smear collection code denied as a bundled service. The Iowa carrier will automatically do a mass adjustment of any visit codes that have been denied due to this edit. On April 21, IMS sent a mini-message to member physicians regarding this development. If you have questions, call Barb Cannon at the IMS, 515/223-1401 or 800/747-3070.

For more information about any *DEADLINE* news item, call Chris McMahon at IMS headquarters, 515/223-1401 or 800/747-3070.

Iowa Medicine

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About the Cover

Dr. Kirk Peterson, a resident in family practice at Iowa Lutheran in Des Moines, monitors a cardiac patient. Photo courtesy of Iowa Lutheran Hospital.

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EDITORIAL

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A new Federation

In his farewell column, the IMS outgoing president discusses the AMA's plan for revamping the organization's structure and functions to better meet physician needs in the future.

● *THE PRESIDENT COMMENTS*

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What responsibilities should a physician delegate to a physician assistant? Who is making the rules governing PA supervision? This month's feature answers these and other questions about the changing relationship of physicians and PAs. Practical information on liability risks for supervising physicians is also discussed.
● *CHRISTINE MCMAHON*

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203 **Changing trends in varicose vein treatment**

An estimated 10-15% of people suffer from varicose veins. This article discusses a less invasive procedure which is replacing high ligation and vein stripping. ● *JA OLIVENCIA, MD*

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BetterCare

A new Federation

American Medical Assoeiation, the Federation of organized medicine, seeks to serve professional needs of physicians in a changing practice, research and educational environment. The AMA House of Delegates adopted a resolution in June, 1993 which endorsed an ad hoc consortium eharged with studying the AMA's organizational strueture and developing recommendations on how organized medicine can function more effieiently, effectively and uniformly to address issues affecting all patients and physicians.

A 200-member consortium and a 30-member projeet team were established to carry out this recommendation. The IMS was represented on the consortium by Dr. John Rhodes, Jr. of Pocahontas.

The initial action report of the study was considered at the December, 1995 AMA Interim Meeting. Some of the principles on which the study is based are as follows: (1) All components of the Federation have a necessary and viable role to play in serving physicians, but in an effort to maximize efficiencies, the role and relationships among these entities need to change; (2) Cooperative and collaborative efforts are a vital element of a new Federation that needs to be initially fostered by a Federation coordination team (FCT) and then quickly made part of the culture of medical society relations; (3) The AMA's House of Delegates is the national forum for organized medicine.

A revised report will be considered by the AMA House of Delegates in June, 1996. The report recommends a mechanism to increase specialty participation and provide incentives for specialty societies to join the AMA. Specialty societies will be eligible for representation in the House of Delegates based on the current criteria and a one-member, one-vote formula. Last year, the IMS House of Delegates recommended similar changes for specialty representation in the IMS House.

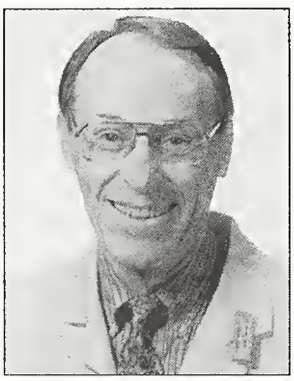
The revised report recommends the Board of Trustees develop a mechanism for participation and representation of various modes of practice (large, small and multispecialty groups and solo practitioners) and other special interest organizations.

The key purposes of the new Federation include uniting in voice and action.

The report also recommends members of the Federation agree to (1) work toward what they believe to be in the best interest of all patients and physicians; (2) share information and knowledge on key public policy issues; and (3) consider established House of Delegates policy as each element of the Federation develops policies and positions.

The key purposes of the new Federation include increasing the value of membership for county, state and specialty societies and uniting in voice and action on behalf of physicians and patients.

If you want a copy of the revised report eontact the AMA at 312/464-4056. IM



JOSEPH HALL, MD

MANAGED CARE

news you can use

University Hospitals, other partners form HMO

University of Iowa Hospitals and several other partners have formed an HMO, the first in which the University has participated. The number of people reached by the HMO will depend on how many enroll through one of its other partners — CommUnity Financial and Insurance Corp. CommUnity is a health and life insurance company owned by IASD Health Services, which operates Blue Cross Blue Shield of Iowa. The other partners are hospitals with working agreements with UI Hospitals for patients. These include Iowa Lutheran Hospital and Iowa Methodist Medical Center in Des Moines and Mercy Health Services which operates hospitals in Mason City, Sioux City, Dubuque and Clinton. The new HMO will replace a managed care system the same partners established in 1994.

Mercy initiates multistate health information network

Mercy Health Services, a Michigan-based hospital system, will test a new multistate health information network in its Iowa region. The network will eventually enable local health care providers to communicate via computer with the system's large medical facilities in Clinton, Dubuque, Mason City and Sioux City. The network can be used for communicating patient information, making referrals and for accessing the Internet.

Physician supply starting to be a problem in some specialties

Physicians in some specialties are having trouble finding work, reports the American Medical Association. Up to 11% of residents graduating in 1994 hadn't found full-time positions in their specialty or subspecialty by January of 1995. Hardest hit were residents in pathology and plastic surgery. Many program directors are looking to reduce residency positions in the next three years.

Integra Health will expand its West Des Moines clinic

Integra Health, formerly Iowa Physicians Clinic, plans to expand its Lakeview Medical Center. The primary care facility will merge with a neighborhood clinic and occupy newly-expanded space on the first floor of the center. The name Integra Health was adopted in mid-February following the merger of Iowa Physicians Clinic of Des Moines and HealthSource of Cedar Rapids. The merged group consists of 37 clinics in central and east central Iowa.

IFMC contract includes review of Medicare HMOs in Iowa

Iowa Foundation for Medical Care has a contractual obligation with HCFA to review Medicare HMO plans. This will include case review, beneficiary complaint investigations and projects similar to those undertaken with hospitals. There are no Medicare HMOs in Iowa, however, IFMC is gaining experience in other states where they have the PRO contract.

Central Iowa multispecialty group looks to the future



It's been 50 years since the founders of McFarland Clinic embarked on what was then a new idea. In Ames in 1946, a general practitioner, a general surgeon, an internist, an otolaryngologist and an obstetrician began one of Iowa's first multispecialty clinics.

These five physieians believed that a multispecialty group practice offered the best means of providing quality medical care. That remains the philosophy at McFarland Clinic today.

Physician-owned, physician CEO

McFarland is completely physician-owned and operated. It is governed by a nine-member physician board of directors elected by the shareholders and employs a full-time physieian CEO, internist Dale Anderson, who also holds an MBA. About 50% of the physicians are primary care providers.

Counting 12 new physicians coming on board this summer, McFarland Clinic, PC will have 129 doctors working in 14 offices in 11 eommunities. In 1995, outpatient visits numbered 500,000.

McFarland's structure has been described as a "rural model" multispecialty group that benefits rural physicians who have ease of referrals, ease of access to specialists, greater support in eall and coverage responsibility and speeialized administrative support.

Non-primary care speeialists benefit from a strong referral base. Physician recruiting is also easier for the large group practice than for individual practices.

Planning for future challenges

Physieian control means a united physician voice when talking to buyers of health care, an important benefit these days. Though McFarland's practice model is not new, those involved say that physician leadership puts the clinic in a strong position to cope with future changes. McFarland's goals for the coming year include:

- Giving every physician and employee 34 hours of training in Continuous Quality Improvement (CQI).
- Regular planning meetings with regional hospital administrators and trustees.
- Creation of a wide network of information systems to connect branch offices, the clinic and hospitals so they can share scheduling and billing information, and lab and radiology information. Ultimately, the network will share electronic medical records.
- McFarland will partner this year with an HMO in introducing a full risk product to its network communities.
- Development of a managed care training program for physicians.
- A restructuring of physician management will create an array of assistant and regional medical directors as well as compensated chairs of key committees such as the quality committee.

What's next?

McFarland Clinic's offices now span Highway 30 from Jefferson to Marshalltown and Highway 35 from Webster City to West Des Moines, but those parameters may widen. The clinic is looking to network with other physicians around the state and Midwest.

Leo Milleman, MD, chair of McFarland's Board of Directors, says the physician-owned structure is the ideal. "The strengths of the organization are the multispecialty approach to care and the strong primary care network. Full-time physician leadership is the key to McFarland's success." IM

McFarland is looking to network with other physicians around Iowa and the Midwest.

This month's story is the first of a series of articles on how various practice groups in Iowa are organizing to cope with the future. In the July–August issue, we will look at a comprehensive physician organization in Davenport. If you know of other such arrangements — especially those controlled by physicians and positioned to compete in the managed care market — call Barb Cannon or Chris McMahon at the IMS, 515/223-1401 or 800/747-3070.



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Wednesday, June 5, 1996

5:30 p.m.—Dinner
6:00 to 10:00 p.m.—Program

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A light dinner, compliments of Mercy Medical Center, will be provided. The four-hour program featuring Steven R. Baker, MD, Senior Physician Consultant, Milliman & Robertson, Inc. will begin at 6:00 p.m. in the Education Center.

This program is designed for physicians (key staff are welcome). The cost is $79 per person.

Registration Form

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1001 Grand Avenue, West Des Moines, IA 50265-3599

IMS Update

MS officers elected April 21

William McMillan, MD, an Ottumwa otoryngologist, was installed as president of ıe Iowa Medical Society on Sunday, April 1. The installation ceremony concluded the ociety's three-day House of Delegates and cientific Session at the Embassy Suites, Des oines.

Other physicians elected to office are:

President-elect (1-year term): Harold iller, MD

Vice-president (1-year term): Hunter ıerste, MD

Trustee (3-year term): Sterling Laaveg, MD

House Speaker (1-year term): Donald ahle, MD

Vice-speaker (1-year term): Tom Throckorton, MD

AMA Delegates (2-year term): Clarence enser, Jr., MD; Bruce Trimble, MD; Donald ung, MD

AMA Alternate Delegate (2-year term): ıomas Graham, MD

District Councilors (3-year terms)

- District 2 Jamal Hoballah, MD
- District 4 Steven Jaeobs, MD
- District 5 Ross Madden, MD
- District 10 Michael Disbro, MD
- District 11 C. David Smith, MD
- District 14 Stephen Richards, DO

At the IMS Annual Banquet April 20, Dr. ın Anderson was given the 1996 IMS Merit ard and Dr. Paul Ferguson was given the ysician Community Service Award. Read out other IMS award winners in the y–August issue of *Iowa Medicine*.

embership Directory verification

In early June, member physicians will ceive a letter to verify their office address- phone and fax numbers, etc. for the 1996- IMS Membership Directory. The directory will be distributed next fall to all member physicians, chambers of commerce, etc.

Please watch for your verification letter and return it promptly to IMS headquarters. This is essential if the directory is to contain the correct information about your practice. In addition, IMS members may advertise their practices in a special section of the directory. This advertising section is intended for use by member physicians making referrals and by the public needing medical services.

For details on how to place an ad in the IMS Membership Directory, call Jane Nieland or Bev Corron at IMS headquarters, 515/223-1401 or 800/747-3070. IM

Specialty Society Update

The Iowa Psychiatric Society Spring Meeting was April 12 at Iowa State University. Fifty physicians attended. Dr. Jerry Lewis assumed the office of president and Dr. Terry Augspurger was elected to the office of president-elect.

The Iowa Medical Group Management Association salary survey is underway. The results should be available at the IMGMA Spring Meeting May 22-24.

The Iowa Society of Anesthesiologists held a business meeting April 13 at the Marriott Hotel in Des Moines. The meeting was attended by 70 physicians. The ISA has asked IMS Services to perform administrative duties for the organization.

The Iowa Society of Rehabilitation Medicine held its spring meeting April 12. Special guest speaker was Rep. Greg Ganske, MD, Iowa's fourth district congressman. Rep. Ganske addressed the group on federal legislation related to Medicare and Medicaid.

For more information on specialty society activities, call Dana Petrowsky or Dave Furneaux at IMS Services, 515/223-2816 or 800/728-5398.

AT A GLANCE

The University of Iowa is one of several schools invited by the AMA to submit grant proposals for its "Binge Alcohol Prevention Program". Colleges invited were among some identified by a recent Harvard School of Public Health study as having the biggest alcohol problems. Other schools included Notre Dame, Wisconsin and the University of Colorado at Boulder.

Some experts agree that between 145 and 185 physicians per 100,000 population is an appropriate ratio for a system dominated by managed care. A current study says the supply right now is about 200 physicians per 100,000 population. People in rural areas actually saw their access to primary care physicians decline since 1995, researchers said.

Legislative Affairs

Legislature wraps up 1996 session

As of press time, the Iowa Legislature was preparing to adjourn for the year. Following is a summary of the status of key bills the IMS has worked on this session:

Group B Strep—HF 2182

The House did not vote on HF 2182, the group B strep bill; however, an amendment was filed to the the Health and Human Rights Appropriation Bill requiring physicians to give information to all pregnant patients and to report the results of group B strep screens to the hospital. The IMS opposed this amendment and it failed on a vote of 30 to 49.

One of the major issues this session for the IMS, HF 2182 would have put into Iowa law a "standard of practice protocol" for screening for group B streptococcus. Based on a yet-to-be-published consensus statement from the Centers For Disease Control, the bill would have required physicians to screen all pregnant women for group B strep between the 35th and 37th weeks of pregnancy.

The IMS does not oppose screening, but strongly opposes putting medical protocols in Iowa law. Because there is no consensus on a "right" answer and accepted practice continually changes, putting medical protocols in the Code will harm patients by limiting the physician's ability to provide care based on the patient's special needs. The legislature is not the best forum for developing a standard of care. The IMS believes that while death of a child or other loved one is tragic, HF 2182 is not a solution to prevention of such deaths.

The IMS will work with specialty organizations to make sure that the most current information on screening and treating group B strep is available to physicians, including the CDC consensus statement.

Individual physicians educating their legislators made the big difference in the outcome of this bill. All those who made phone calls, wrote letters, lobbied at the Statehouse, organized meetings with legislators or wrote letters for distribution to the House of Representatives deserve recognition for their important contribution. This bill would not have passed without your help.

Statute of Limitations for Minors—HF 394

A major priority of the IMS this year was to reduce Iowa's extended statute of limitations for minors in medical malpractice cases. Current law provides that a lawsuit may be brought for an alleged birth injury until the child reaches age 19. At that time the normal statute of limitations is in effect. HF 394 provided that the normal statute of limitations would begin running at age 6.

HF 394 passed the House in 1995, but it failed to receive committee approval in the Senate when Senator Tom Vilsack, a trial lawyer, threatened to keep the committee busy for hours with amendments.

Maternity Care—HF 2369

As of press time legislators continue to struggle with the issue of health benefit coverage for maternity care. The House and Senate have passed different bills.

The Senate bill, SF 2162, requires third party payers to cover care recommended by the attending physician when following the most recent Guidelines for Perinatal Care approved by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. The House bill, HF 2369, specifies that coverage must be provided for 48 hours after a vaginal delivery or 96 hours following a C-section.

Assault Against Health Care Workers—SF 2167

A successful initiative of the IMS this year was to increase the penalties for assault against health care workers. The Iowa chapter of the American College of Emergency Physicians worked with the IMS to make this a priority. The bill's enhanced penalties are expected to deter patients or their companions from bringing violence into the hospital.

AT A GLANCE

Des Moines physician Stephen Gleason, DO has been appointed senior health policy adviser to President Clinton's reelection campaign. Gleason is president and chief medical officer of Mercy Clinics in Des Moines.

In early March, a federal appeals court struck down the Washington state ban on assisted suicide, a law which is similar to one passed by the 1996 Iowa Legislature. The court issuing the ruling does not have jurisdiction in Iowa. However, Iowa lawmakers predicted the issue will ultimately come before the U.S. Supreme Court because so many states have passed similar laws.

Similar enhanced penalties are already provided for assaulting law enforcement officers and firefighters. SF 2167 has passed both houses and been signed by the governor.

Any Willing Provider/Direet Access to Care —HF 2298/SF 2389

Several "any willing provider" and "direct access" bills are under discussion by the legislature. Bills have been introduced by limited license practitioners who wish to ensure their place in managed care plans through legislation. Bills prohibit plans from requiring physician gatekeepers for limited license practitioners and prohibit MDs from serving as gatekeepers for DOs and vice versa.

HF 2298 and SF 2389, the direct access to chiropractors bills, remain on both the House and Senate calendars but neither has been brought to a vote. The IMS supported an amendment to HF 2298 which would have required managed care plans to offer a point-of-service plan to small employers and would require large employers to offer employees at least one of three plans which allow choice of physician.

The IMS opposes these kinds of mandates. Such mandates only apply to the portion of health care benefit coverage regulated by the state; they do not apply to self-insured employers regulated by the federal ERISA law. (The IMS estimates that about 50% of employer-provided eoverage is ERISA-regulated, 25% is Medicare and Medicaid and the remaining 25% is state-regulated health benefits.) The IMS is working with the business and payer communities to try to resolve such issues as patient aceess to physicians, due process and gag rules within managed care.

Dentistry Scope of Practice—HF 2201

In its original form, HF 2201 would have allowed the Board of Dental Examiners to define the seope of practice of dentists which is unpreeedented in Iowa law. The IMS was concerned that the original bill would allow the Board of Dental Examiners to declare reconstructive surgery to be within the scope of practiee of dentists. The dental board initiated the bill to update and fix a minor problem in their practice act.

The IMS has worked with plastic surgeons to rewrite the bill to fix the problem without expanding the scope of practiee beyond normal dental practice. Both houses have passed a compromise amendment which significantly improves the bill, although it does not completely alleviate our concerns.

CHMIS Delay—SF 2218

SF 2218 delays implementation of the Community Health Management Information System for one year, to July 1, 1997, to give the governing board more time to decide the future of CHMIS. SF 2218 has passed both houses and been signed by the governor.

Parental Notification of Abortion—SF 13

SF 13 requires physicians to notify a parent or other specified close relative prior to performing an abortion on a minor. The bill also requires physicians who perform abortions to make available in their offices a video explaining the procedure. SF 13, as passed, is a compromise that neither side of the abortion debate is completely satisfied with.

IMS policy encourages physicians to help the minor notify her parents but states that such a requirement should not be in the law because of differing family circumstances. SF 13 has been signed by the governor.

Assisted Suicide—SF 2066

The legislature has approved and the governor has signed SF 2066 providing for criminal penalties for assisted suicide. The bill contains language making clear that the penalties do not apply to physicians managing the pain of dying patients. The IMS worked extensively on the bill to ensure that it would not interfere with the practice of medicine and supported the version that passed as being consistent with the ethical opinion of the American Medical Association.

Medical Record Fees—SF 258

The IMS was successful in preventing House debate of a bill which would have directed the Department of Public Health to set fees charged to attorneys by physicians and hospitals for copies of medical records.

Other Issues

The IMS has worked on many other bills this year. Those not completed as of press time include appropriations for the state Medicaid program, the family practice residency program, the Board of Medical Examiners, the Department of Public Health and state medical examiner. IM

The IMS does not oppose screening, but strongly opposes putting medical protocols in Iowa law.

Medical Economics

IMS DATA PROJECT IMPLICATIONS FOR FUTURE

IMS is undertaking a data project to aid physicians in analysis of their practice patterns and help them compete in the new health care delivery market. The project will utilize historical and current claim data, adjust the data to account for patient severity differences and produce individual physician profiles which can be used to compare outcomes to peers.

As the project develops, tools to measure satisfaction, quality and outcomes will be incorporated. The IMS has joined with QuadraMed, a national electronic data interchange company, for the project. QuadraMed offers an extensive array of data, analysis, reporting and technology services which physicians should find valuable while analyzing many aspects of their practices.

Data is of paramount importance in negotiations for discounted fee-for-service contracts, managed care participation, capitation contracts, mergers with other physicians or hospitals, etc. The IMS believes services such as the data project will benefit physicians as they meet the challenges of the ever-changing health care environment. Watch for an announcement of regional meetings sponsored by IMS around Iowa to discuss the data project in more detail.

If you want more information about this important project, call Ed Whitver, manager of health care data, information and services at the IMS, 515/223-1401 or 800/747-3070.

AT A GLANCE

The Clinical Laboratory Improvement Act of 1988, which forced many physician office labs to either close or reduce testing done on-site, has added an estimated $1.3 to $2.1 billion to our nation's health care bill, according to a recent report from the American Academy of Pediatrics.

The U.S. Supreme Court decision to let stand a lower court ruling that cleared Wisconsin's Marshfield Clinic and its HMO of key antitrust allegations could spark new conflict over what constitutes a monopoly. Enforcement officials are struggling to reconcile differences between the Marshfield ruling and more restrictive federal guidelines.

Firms that once shunned Medicaid are eyeing the market opened by state managed care programs. Experts say the firms will bail out when profits dry up.

Progress on new Medicare payment

In the April 3 issue of *JAMA*, HCFA Administrator Bruce Vladeck said that organization "looks forward to working closely with the physician community" as they complete an initiative to change the way physicians are paid by Medicare.

The practice expense portion of physician payments will no longer be based on past charges but will reflect the relative resources used to provide the service.

Making the new system work will depend on a massive data collection effort involving significant participation by physicians. Physicians will be surveyed regarding overall indirect costs of practice. Iowa physicians will be included in that survey.

In addition, Clinical Practice Expert Panels will provide data on the direct costs of providing specific services. Results from the physician surveys and the CPEPs will be an important element in the development of the new physician payment system, said Vladeck.

The new relative values are scheduled to be implemented January 1, 1998 and will be updated periodically.

Medicare projections worsen

Medicare's budget outlook is even more dismal than experts believed, according to the latest figures.

Based on briefings from the federal actuaries who monitor the Medicare Trust Fund, Republicans in Congress now say that the Part A fund will go broke in 2001 rather than 2002, as earlier predicted.

HCFA officials confirmed that the project bankruptcy date is advancing, but said current estimates are still preliminary.

Republicans took the opportunity to criticize President Clinton for vetoing the balanced budget plan, which contained Medicare reform. Republicans said Congress can no longer "bury our heads in the sand". However, Democrats said the figures were no surprise to anyone.

LEGISLATURE APPROVES DELAY IN CHMIS IMPLEMENTATION

Activity in the CHMIS arena has been sparse since the Governing Board approved a recommendation at its February meeting to develop a new CHMIS model. The CHMIS Executive Committee has been sorting out the logistics of how the new model should be developed, who should be included in the process and charges for three advisory committees.

Another crucial issue is how CHMIS will be funded after June 30, 1996 when the Hartford Foundation grant expires.

The CHMIS Governing Board recommended to the Iowa Legislature a one-year delay in the implementation of CHMIS in order to develop a more cost-effective model. As of press time, the bill had passed the Senate and House and was scheduled to go to the Governor for signing.

Therefore, physicians will not be required to contract with an electronic network to send insurance claims electronically by July 1, 1996 as specified in the original CHMIS law. Any CHMIS requirements for physicians will not go into effect until at least July 1, 1997.

Hopes dim for liability reform

The battle over tort reform in Congress — and between the President and Congress — continues. The hardening of battle lines appears to have dimmed prospects for meaningful medical liability relief this year.

Nevertheless, proponents of professional liability reform have made major progress this year, says the AMA. The AMA, its allies from other segments of the health care sector and thousands of physicians who contacted their lawmakers were a signficiant factor in the growing political awareness of tort reform as a key element in health system reform.

In addition, public awareness of the problems inherent in the current system has reached its highest level.

The medical profession is also taking a look at specific treatment outcomes and identifying situations in which patient injuries are likely to occur.

HCFA plans huge patient survey

The Health Care Financing Administration is planning to conduct a sweeping survey of the health care delivered to nearly four million Medicare beneficiaries, *Modern Healthcare* reports.

The survey, planned for the end of this year, will be one of the largest health care consumer satisfaction surveys ever undertaken. Medicare beneficiaries will be asked for information that will be used to compile an "apples to apples" comparison between HMOs and managed care and fee-for-service systems, said Bruce Fried, director of HCFA's Office of Managed Care.

Fried said beneficiaries will be questioned about issues of satisfaction and quality.

The survey will probably be conducted over the telephone. Several agencies, including the Agency for Health Care Policy and Research, are designing the survey questions, reports *Modern Healthcare*. IM

IMS is undertaking a data project which will help physicians compete in the new health care delivery market.

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Practice Management

1996 practice management seminars

(Watch your mail for specific details and registration forms. Most of these seminars count toward the MBS Certificate Program.)

CPT Coding — Tues., June 4, 9 a.m.–4 p.m., Des Moines.

Managing Patient Care Using Milliman & Robertson Guidelines — Wed., June 5, 6–10 p.m., Cedar Rapids.

Resource Management — Thurs., June 6, 9 a.m.–4 p.m., Cedar Rapids.

How to Collect for Control — Tues., June 11, 9 a.m.–4 p.m., Davenport. This seminar will also be given in Des Moines on Wed., June 12 and in Sioux City on Thurs., June 13.

Living the Ergonomic Way — Tues., June 18, 10 a.m.–2 p.m., Des Moines.

Health Insurance Overview — Thurs., June 27, 10 a.m.–2 p.m., Des Moines.

Office Safety, Tues., July 30, 10 a.m.–2 p.m., Des Moines.

Update on pap smear collection codes

Despite efforts by the IMS, AMA and national specialty societies, little progress has been made on Medicare's AdminaStar/ Correct Coding Initiative. There continues to be a high level of frustration regarding the illogical bundling and the policy of paying for the least costly procedure.

However, progress has been made on the pap smear collection fee issue. (See story on page 150 of the April *Iowa Medicine*.) Due mostly to efforts by the IMS, HCFA has changed this edit and will begin paying for the office visit service. According to the Iowa Medicare carrier, pap smear collection charges associated with the payable Medicare benefit (see January 1994 *Medicare Info*) can be billed with an E & M code. However, the codes must be identified with the -GB modifier in order to be paid (i.e., Q0091 -GB).

continued

AT A GLANCE

Diane Marshall, office manager for Dr. Randall Maharry in Des Moines, is the recipient of the 1996 Outstanding Medical Office Administrator of the Year Award. Ms. Marshall has worked in Dr. Maharry's dermatology office since 1975.

In case you haven't heard, the Iowa Legislature approved a request from the CHMIS Governing Board to delay implementation of CHMIS for one year. During this year, the Board will decide what direction CHMIS will take. In the meantime, pressure is off physicians' offices trying to prepare for the original July 1, 1996 deadline. This month's Medical Economics, *page 190, has more details about the CHMIS delay.*

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Patient compliance

A 31-year-old with a history of moderately abnormal pap smears came to her physician during her third pregnancy. A pap smear showed moderate to severe dysplasia. She refused further tests because she was pregnant. Her physician recommended testing after delivery. She returned for a six-week checkup following the birth, but a pap smear was not done because she was bleeding. The physician instructed her to return soon for further tests. She returned seven months later for abnormal bleeding and was diagnosed with invasive cervical cancer. She filed a malpractice claim alleging the physician failed to diagnose her cancer in a timely manner.

The Bayer Institute for Health Care Communication, which tracks studies on patient compliance, reports that half of all patients ignore their physician's advice. Why? Among other reasons, some patients may not understand the reasoning or urgency behind the physician's instructions.

If a patient's noncompliance leads to an injury or complication, they may file a malpractice claim alleging their noncompliance resulted from unclear, inadequate or omitted advice from the physician. Reduce your liability exposure by:

- Explaining clearly the treatment plan and the risks of not following instructions. Stress the urgency of follow-up care and document these conversations in the patient's record.
- Utilizing handout instruction sheets so patients don't have to rely on their memory.
- Using reminder or tracking systems to contact patients who need follow-up.
- Documenting failed appointments; contacting patients whose missed appointments put them at risk.

For further information, contact Lori Atkinson, MMIC risk management supervisor, MMIC West Des Moines office, PO Box 65790, West Des Moines, Iowa 50265, 800/798-9870 or 515/223-1482.

Practice Management
continued

There is still time to enroll in these IMS Services seminars:

Quality in the Medical Office
Wed., May 15
9 a.m.–4 p.m.
Cedar Rapids

Resource Management
Thurs., May 16
9 a.m.–4 p.m.
Sioux City

ICD9-CM Coding
Thurs., May 16
9 a.m.–4 p.m.
Des Moines

Call Sherry Johnson at IMS Services to register.

Other changes to the original edits have been made. The IMS is working through AMA to get a cumulative list of the changes. This list will be made available to IMS members.

According to HCFA and the Iowa carrier, any codes that are denied due to the AdminaStar edits that are later changed will be automatically reprocessed and paid through a mass adjustment once each quarter. *(In Iowa, these adjustment claims will be identified by an ICN beginning with 47 on the provider remittance notice.)*

Because there will be mass adjustments, physicians should not resubmit these services. However careful tracking should be done by physicians to ascertain that all corrections are made. Any services that were not originally submitted can be submitted for payment once an edit is changed.

In Iowa, AdminaStar denials were identified with "098" denial messages until March 15, 1996. After that, the denial changed to "B15" under the new ANSI standard denial message.

The IMS is continuing to work with the AMA and specialty societies on the problem edits. Examples of edit questions can be sent to Barbara Cannon at the IMS. IM

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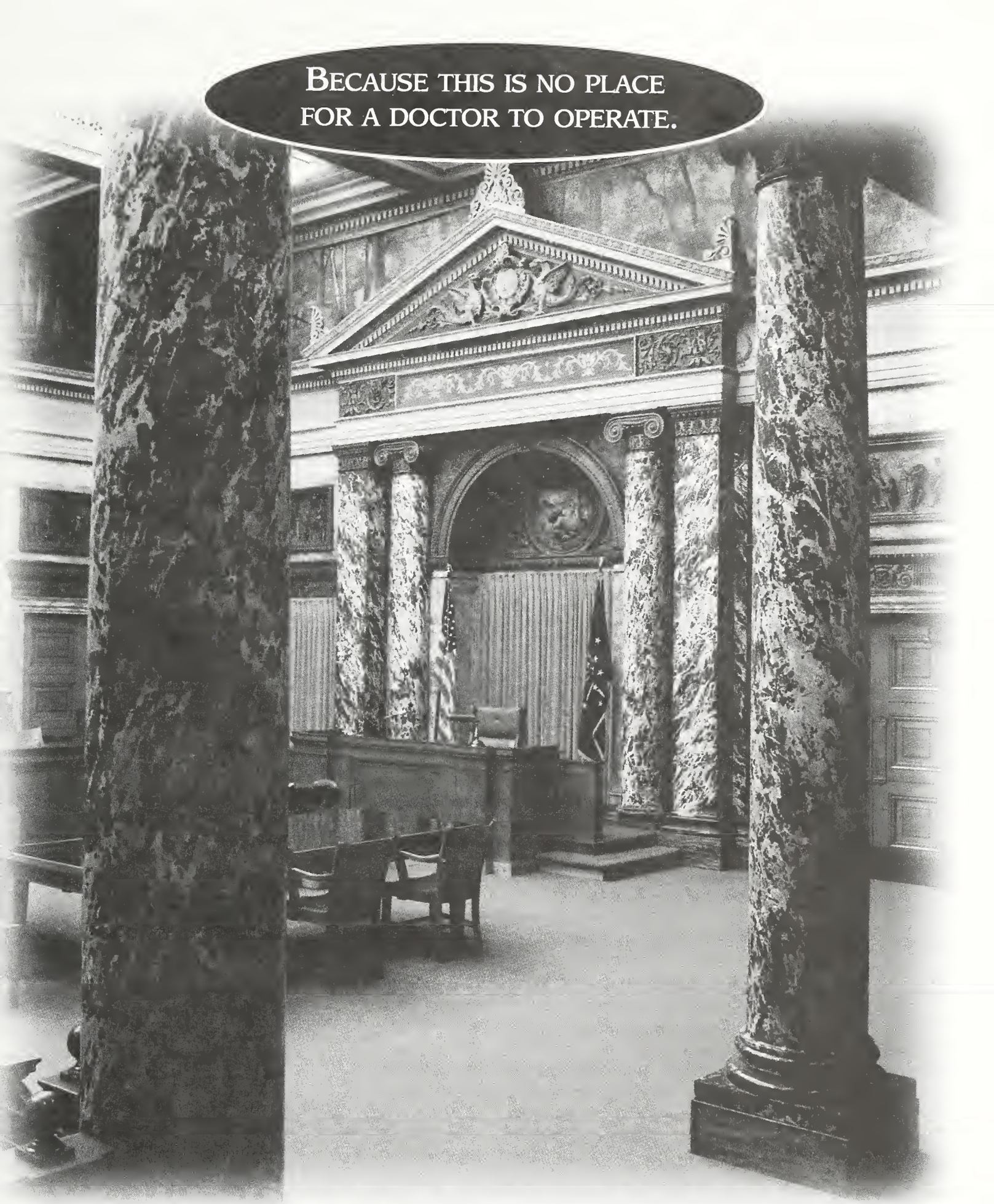
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Newsmakers

AT A GLANCE

Semler Medical Office, Story City, has joined McFarland Clinic. Dr. Charles Semler and Dr. Nancy Carlson will continue to practice family medicine in their present Story City location.

Iowa Physicians Clinic Medical Foundation, HealthSource and STL Health Resources has changed its corporate name to Integra Health. Integra Health, an affiliate of Iowa Health Systems, is one of the largest physician groups in Iowa with 160 providers and nearly 311,000 patients from 37 locations in central and eastern Iowa.

The March issue of American Health *magazine lists five physicians from the UI Hospitals and Clinics among the "Best Doctors in America". The list includes Drs. Lawrence Hunsicker, internal medicine; Bruce Gantz, otolaryngology/head and neck surgery; Arnold Menezes, surgery; William Scott, ophthalmology and Richard Williams, urology.*

"Chart management"

Dear Editor:

I wanted to comment on the front cover photo of the February issue of *Iowa Medicine.* This was obviously a posed picture so my comments are not directed at Dr. Langely, but at the interpretation of the picture itself.

He looks to be rather self-satisfied and pleased with the use of the computer and undoubtedly has a good record, but isn't it interesting that he has his attention turned toward the computer and not toward the patient, where the patient is looking directly at him. The nurse seems to be paying more attention to the patient than the doctor is. Perhaps this is another example of "chart management" as opposed to "patient management". Sometimes we get so carried away with having a perfect record that we forget about the patient. —*Dr. Dean Harms, Ames*

Letter *to the* Editor

Awards, appointments, etc.

Dr. Dennis Boatman, Cedar Rapids, headed up a United Way campaign which raised $5.2 million for six counties in east central Iowa. **Dr. Kishore Thampy,** psychiatrist, has begun practice with **Dr. Tom Pickenbroek** at the Gannon Center in Dubuque. **Dr. John Callaghan,** Iowa City orthopaedic surgeon, was recently appointed to the board of directors of the American Academy of Orthopaedic Surgeons. **Dr. Lisa Brothers Arbisser,** Davenport ophthalmologist, has been reelected for a one-year term on the board of directors of the American College of Eye Surgeons. **Dr. R. Josef Hofmann** recently travelled to Huasca, Hidalgo, Mexico where he operated an eye clinic. Dr. Hofmann has been travelling to Mexico for more than 20 years as part of the Davenport Diocesan Volunteer Program. **Dr. John Collins,** family practitioner, recently travelled to Medina, Brazil as a volunteer for the same Davenport program. **Dr. Daniel Laehanee,** neurologist, has begun practice at Medical Associates in Dubuque. **Dr. Timothy Loth** of Iowa Medical Clinic in Cedar Rapids, is the editor of a new medical textbook entitled *Orthopedic Boards Review II: A Case Study Approach.* This 455-page book follows Dr. Loth's first book, *Orthopedic Board Review,* published in 1993. **Dr. Diane Crowley** and **Dr. Dennis Straubinger,** family practice, have joined FirstMed Clinics in Davenport. **Dr. Duane Whitaker,** UI Hospitals and Clinics, has been elected president-elect of the American Society for Dermatologic Surgery. **Dr. William Barnett,** general surgeon, has retired after 35 years of practice at McFarland Clinic in Ames. **Dr. Daniel Waters,** Mason City general and cardiovascular surgeon, has written a book entitled *A Heart Surgeon's Little Instruction Book.* The book is a collection of short bits of wisdom and practical advice, garnered from the author's medical experiences. **Dr. J. Douglas Watts,** has joined Indianola Family Practice which is a part of Integra Health. Primary Health Care Associates of Northeast Iowa is now affiliated with Integra Health; **Dr. Thomas Spragg** has been named medical director for the Waterloo/Cedar Falls region. **Dr. Curtis Hass** and **Dr. Kathleen Nordstrom,** radiation oncologists, recently joined Iowa Cancer Care/Oncology Associates of Cedar Rapids. **Dr. Susan Kambhu** and **Dr. Rodney Zeitler,** Department of Internal Medicine, UI Hospitals and Clinics, have joined **Dr. Richard Corton** as associate medical directors of Iowa City Hospice. **Dr. James Friederich,** orthopedic/hand surgery, has joined McFarland Clinic in Ames.

Deceased members

Charlotte Fisk, MD, 93, life member, pediatrics, Des Moines, died March 7

Jaek Spevak, MD, 79, life member, pediatrics, Des Moines, died April 1 IM

Emergency Physician Practice Opportunity

***Dubuque Emergency Physicians**, P.C. is a 4-member group practice that has provided 11-years of care at Mercy Health Center, Dubuque, Iowa. Mercy Health Center, St. Joseph's Unit at Dubuque is a 410-bed medical center that services a tri-state area. We are seeking a BC/BP Emergency trained physician or a boarded physician with extensive emergency experience for a full-time position. Become the fifth member of our team in a modern ED with 23,000 annual visits and weekend double coverage. This position offers exceptional compensation and benefits, plus a short time to partnership. Dubuque, Iowa is a family oriented community located on the scenic Mississippi River. You will enjoy a lifestyle unsurpassed by any other region in the country. Dubuque, Iowa offers a matchless public and parochial school system, a strong and growing economic base, and ample recreational and cultural activities.*



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Iowa physicians, PAs see evolving relationship

No matter what side of the professional fence you're on, it's obvious that physicians' relationships with allied health practitioners are changing. This article examines the general condition of the physician/PA relationship in Iowa.

As health care delivery changes, it is no surprise that the role of allied health care practitioners — especially physician assistants — is changing, too. It is also not surprising that this evolutionary process is a source of consternation for physicians trying to stay up to date on their supervisory responsibilities.

Complicating the situation, say some experts, is the fact that there is "lingering resentment" between Iowa physicians and physician assistants which dates back years. However, people interviewed for this article say that everyone is trying hard to overcome it and move ahead.

Working to overcome resentment

"There has been a tenseness which dates back to the time when PAs were regulated by the Board of Medical Examiners," admits Ann Martino, executive director of the BME. "Unfortunately, it has sometimes affected our ability to cooperate, but we are working diligently to overcome this."

There is lingering resentment which dates back years, but everyone is trying hard to overcome it and move ahead.

Physician assistants in Iowa, unlike many other states, have their own PA Board and are not regulated by the BME. There reportedly is conflict between these two boards, some of which stems from the fact that the respective responsibilities of these boards had not been clearly defined. However, the Attorney General issued a recent ruling regarding responsibilities for PA rule-making which most people believe will help resolve some of the problems.

According to Ann Martino, the BME's role is to make sure physicians who supervise PAs are qualified to do so. The Board of Physician Assistant Examiners has statutory authority to regulate the conditions of the PA's relationship with the physician. PAs who do not follow the rules are subject to disciplinary action by the PA Board, she adds.

Dr. David Carlyle, a member of the Iowa Medical Society's PA/NP Task Force, says there is plenty of

Christine McMahon
Ms. McMahon is IMS director of communication and editor of Iowa Medicine. *This article was written with the assistance of Becky Roorda, IMS director of public affairs.*

confusion about the rules and their interpretation.

"There are so many entities involved in issues surrounding physicians and limited practitioners and they all have their own perspective on how things should work," he explains. "I can almost guarantee you that most physicians don't understand the nuances of the laws and rules governing their supervisory role."

The occasional conflict between the BME and the PA Board mirrors that of the two professions, contends Bery Engebretsen, MD, also a member of the IMS PA/NP Task Force. He believes that historically, too many physicians have had a negative attitude toward PAs.

"Physicians must realize that each person is part of an interdependent team. That's how things are really supposed to work," Dr. Engebretsen comments. "Personally, I want to see some of this bad blood fade away and all of us work together."

Practice scope is source of confusion

Ann Martino says Iowa physicians call the BME office "with all kinds of questions about supervisory responsibilities"; Iowa Medical Society staff report a similar experience.

"The source of most confusion is the scope of PA practice as determined by the physician. This is caused by the fact that physicians have wide discretion in this area, but also a great amount of responsibility. There is no separate standard of care for PAs. Society expects the same quality of care," adds Ms. Martino.

The PA scope of practice as defined in the law and in rules is deliberately vague so that physicians can take into account the PA's abilities and the practice situation. However, this vagueness is a major source of concern for physicians who are concerned about patient welfare and liability.

"Physicians wonder how closely they should supervise PAs. They wonder how often they should review PAs and they wonder what PAs should be doing as far as procedures," agrees Dr. Carlyle. "Because much of the PA's scope of practice is decided by the physician, the most important thing is for them to be familiar with the PA and what the PA is capable of.

Dr. Engebretsen says he believes physicians and PA's can work together well as "collaborating professionals who understand each other's training and experience."

According to Dr. Carlyle, "the ideal working relationship between a physician and a PA is where the professionals know each other's practice style and the PA knows his or her limits and when to call for help."

Both Dr. Carlyle and Ann Martino say that

continued

"The ideal relationship between a physician and a PA is one where they know each other's practice styles and the PA knows his or her limits and when to call for help."

IMS HAS COPIES OF PA RULES

For copies of laws and rules pertaining to PAs and PA supervision (Iowa Code and rules of the Board of Medical Examiners and the Board of PA Examiners) call Becky Roorda at the IMS, 515/223-1401 or 800/747-3070.

more education is needed.

"Much of the confusion is understandable, but physicians need to pay closer attention to these issues," comments Dr. Carlyle.

"I believe we need better education of both physicians and PAs. Both professions need to understand their responsibilities and their limits," adds Ms. Martino.

"I believe we need better education of both physicians and PAs. Both professions need to understand their responsibilities and their limits."

IMS task force working on statement

The Iowa Medical Society appointed a PA/NP Task Force for the purpose of sorting through some of these knotty issues.

"We need to develop a coherency in these issues involving physicians and limited practitioners," explains Dr. Carlyle. "One of the things our task force has been working on is a clear, common statement of our philosophy regarding limited health practitioners. A statement physicians can feel comfortable with." ***(As of press time, this statement was awaiting approval by the 1996 House of Delegates.)***

What about the future?

Some believe that physicians may be depending on PAs and nurse practitioners even more in the future — particularly in rural areas.

"The situation in rural Iowa is such that we can't maintain the physician base. We'll be looking to PAs and NPs to provide more of these services. Also, medicine changes so quickly and there is such a vast amount of knowledge out there that PAs can play a key role in maintaining quality of care while physicians are trying to stay current."

"As we get to know each other in a professional sense, we can put all this past stuff behind us and look toward a more positive future," concludes Dr. Engebretsen. IM

Common questions on PA supervision

Are there minimum legal requirements for supervising a PA (frequency of visits, signing of charts, etc.)?

Patient care by the PA must be reviewed by the supervising physician on an ongoing basis according to the patient's condition. While the physician is not required to sign every chart, review every visit or be present at each PA activity, the physician is ultimately responsible for the care each patient receives. Patient care may be reviewed in person, by telephone or by other telecommunication. Training in new tasks may be carried out only under direct supervision of the supervising physician or other qualified individual. A supervising physician must visit a remote clinic at least every two weeks unless special circumstances arise. (This requires notification of the PA Board.)

Can a PA practice at a remote site immediately after graduation?

No. The PA must have a permanent license and at least one year of practice as a PA before practicing at a remote site. This requirement may be waived by the Board of PA Examiners if the PA has a permanent license and six months of practice as a PA and the supervising physician and PA have worked together at the same location for a period of at least three months prior to practice at the remote clinic. The supervising physician must review patient care given by the PA at least weekly and sign all charts on patient care rendered without documented direct consultation with the physician during the first year of the PA's practice. Please remember, PAs do not have a residency after graduation. The supervising physician is responsible for ensuring that the PA has the skills and experience to do what is delegated.

What is a PA allowed to do?

The PA's scope of practice encompasses whatever is delegated by the supervising physician, recognizing that the physician remains ultimately responsible for the care provided by the PA. For example, a physician may delegate to the PA the authority to prescribe drugs (including controlled substances) or to order and interpret x-rays. The physician also has the authority *not* to delegate duties he or she is not comfortable delegating. The physician should not delegate activities that are outside the physician's own area of expertise. The supervising physician should be sure the PA has training and experience in all activities that are delegated. Before you supervise a PA at a remote site, be sure you are familiar with the PA's training, experience and skill level.

Who shoulders the risk?

Liability and allied health providers

Physicians frequently employ allied health professionals in their offices or clinics. While these extenders can save physicians time and provide quality care, they also pose liability questions.

Understanding your duties and responsibilities regarding health practitioners can help you identify gaps in your practice that may expose you to a malpractice claim.

Duty to supervise

In malpractiee law, as in other areas, an employer is responsible for the negligence of an employee operating within the seope of his or her employment. Thus, if you employ a nurse practitioner, a physician assistant or a physical therapist and that person injures a patient, the law ultimately makes you responsible. In many situations, the supervising physician could have or should have caught the errors.

The physician's duty to supervise may require working as a eollaborative team to minimize risk to patients. By encouraging your employees to function as a health care team, you can improve the continuity of care provided to all your patients.

If you already employ or are considering employing allied health providers, ask yourself these questions:

Do you know the scope of your allied health professionals' praetice? If an allied health provider is giving care outside the scope of his or her license or certification, you may be facing a malpractice risk. Be aware of the licensing requirements for each nurse, physician assistant, therapist or other provider. Establish written guidelines or protocols to ensure their practices are always within that scope.

Do you properly identify allied health providers at your office? A patient who believes he is being treated by a physician may feel deceived if there is an adverse outcome. Such a patient may be more likely to sue than one who understands the allied provider's role on the health care team. Make sure all allied health professionals in your practice are clearly identified as PAs, RNs, NPs, etc.

In addition, allied health providers should immediately and tactfully correct any patient who mistakenly calls them "doctor".

Do you have an ongoing process for reviewing care provided by allied health praetitioners? Chart reviews, case discussions and open communication all contribute to the growth and development of a team. A good supervisory relationship will satisfy the allied professional's licensing requirements, help prevent mistakes that lead to patient injuries and close a potential malpractice gap in your practice.

Liability insurance issues

Generally, when a physician or clinic employs allied health providers, the physician's or clinic's insurance covers those persons, provided they are working within the scope of their employment. When you hire an allied health professional, notify your carrier. Your insurer will want to know the person's credentials and what his or her duties will be.

continued

Chart reviews, case discussion and open communication all contribute to the growth and development of a team.

DEBRA MCBRIDE, RN, JD
Ms. McBride is a risk management consultant with Midwest Medical Insurance Company. This article is reprinted with permission.

The law does not automatically hold the physician harmless when the allied provider is an independent contractor. Rather, the nature of the relationship and the physician's right to direct and control the allied provider are examined.

If you work with a nurse, a therapist or a PA who is an independent contractor, find out what malpractice coverage they have and notify your carrier of the relationship. (The law may require allied providers who work independently to carry their own malpractice coverage. You may wish to find out about this when checking into their credentials.)

Physicians who refer patients to athletic trainers, physical therapists or psychologists should also inquire about their liability coverage. When sending a patient to one of these caregivers, you should use the same good judgment you would use when making any other referral. It is always good practice to know the person to whom you refer your patients and to have information about that practitioner's skills and training.

While using allied professionals in your practice can benefit you and your patients, it is important to recognize potential pitfalls and to close any malpractice gaps before problems arise. IM

The law does not automatically hold the physician harmless when the allied provider is an independent contractor.

RECOGNIZING LIABILITY RISKS . . . CASES FROM MMIC FILES

Example: A 50-year-old man complained of rectal bleeding. He was examined by a PA who diagnosed hemorrhoids. The PA did not recommend follow-up. The patient's subsequent visits with the same complaints led to the same diagnosis by the PA. The PA never referred the patient to a physician. Within a few months, the patient was hospitalized with a rectal tumor.

Liability issue: The patient's continuing complaints called for consultation with a physician. Though the clinic had a colorectal protocol, it was unclear regarding hemorrhoid symptoms. The supervising physician was unaware of the repeated visits. The patient sued the clinic and the physician.

Risk management tip: Written protocols must be clear. Every health professional in the clinic should be familiar with them. The protocols should include written guidelines for examination, treatment, ability to delegate, supervision and physician access. A physician should always see a patient after a predetermined number of visits for medical reasons and to promote good patient relations.

Example: A new mother calls the clinic and says her three-week-old has a runny nose and fever. The office nurse who takes the call advises the mother to give the child Tylenol and use a cool mist vaporizer.

The mother calls the following day and reports the child is lethargic. Another office nurse says lethargy could be a reaction to Tylenol, but suggests the mother might want to bring the child in to see the physician.

Neither call is documented. Sensing no urgency, the mother waits until the following day. When she arrives at the clinic, the child is already moribund with pertussis.

Liability issue: The nurses in this case were not qualified to diagnose the infant's illness and lacked adequate guidelines for handling such telephone calls. The failure to document the calls devastated the defense of the claim.

Risk management tip: Use only appropriately trained, qualified staff for telephone triage. Make sure that anyone doing such work follows written protocols or guidelines and documents any symptoms related or treatment advice.

The Journal
of the Iowa Medical Society

Changing trends in varicose vein treatment

● JA OLIVENCIA, MD

Varicose veins remain among one of our most common and oldest afflictions. It is estimated about 10-15% of the world population suffers from varicose veins. It is about four times as common as arterial problems in the general community.

For a number of decades the mainstay of treatment of varicose veins has been high ligation, stripping and excision. This remains the most commonly performed procedure for varicose veins in the U.S.

However, in most of the major teaching centers in Europe, high ligation and stripping of varicose veins has been essentially surplanted by much lesser invasive, yet effective, procedures. The first among these has been sclerotherapy. This was followed more recently by ambulatory phlebectomy.[1-5]

Sclerotherapy treatment

Sclerotherapy for the treatment of varicose veins was widely used during the late 1800s and early 1900s. However, the many subtleties of the procedure were not properly understood and the procedure fell into disrepute. It again took hold during the past three to four decades and today it is the most commonly performed treatment for varicose veins in Europe.

Medium and small size varicose veins respond quite well to compressive sclerotherapy. More recently ultrasonic guided sclerotherapy of larger varices and the saphenofemoral and saphenopopliteal junctions has been described. Treatment of these junctions has generally been considered a contraindication to sclerotherapy. Experience with ultrasonic guided treatment of the latter is encouraging but needs more time to be fully assessed.[6]

One must never underestimate the importance of the postoperative compressive dressing which is an integral part of the procedure. This, along with a good follow-up program, are needed in order to assure good to excellent results.

Sclerotherapy offers many advantages. It can be performed in an office setting. The sclerosing agents have been perfected and for the most part are innocuous. Patients can return to their daily activities after each treatment. Complications are uncommon and when they do occur, are generally temporary and minor.

Ambulatory phlebectomy procedure

A minor procedure which is becoming popular is the micro-extraction of veins or ambulatory phlebectomy. This minor procedure entails the use of very small incisions, from 1mm to 5mm in length. The incisions are made parallel to the long axis of the lower extremity. The exposed vein is then delivered from the wounds by specially designed hooks. The vein is then divided between mosquito clamps. By rolling and pulling the vein which is kept under constant traction, varying lengths of vein can be avulsed. The cosmetic result is excellent. Complications are infrequent, mostly due to the size of the wounds and maneuvers used to extract long segments of vein. A properly applied and fitted compressive dressing postoperatively helps minimize complications.[7-10]

Ambulatory phlebectomy, as its name indicates, is performed in an office setting under local anesthesia. Patients return to their daily activities after each treatment. As is the case with sclerotherapy, there is no

The IMS Education Fund has designated this article as the Henry Albert Presentation Award for May–June 1996.

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Changing trends in varicose vein treatment

continued

need for hospitalization.

Both sclerotherapy and phlebectomy are commonly used in the same patient. The extremity is not only spared unsightly incisions, but only the varicosed part of the superficial venous system is removed, saving healthy veins for future surgical use.[1-5]

In a recent study of 383 patients, the morbidity rate was 6.9%. Distribution was 83% females and 17% males with an average age of 46.2 years (ranging from 19 to 79 years). The principal complication was the compressive dressing. A properly fitted compressive dressing on a large and muscular extremity may be difficult to maintain. Blister formation, especially noted in the popliteal region, was the most common complication. Ecchymosis of the skin is frequently encountered and resolves in a few days. Wound complications are otherwise uncommon.

As more experience is gained with these lesser procedures, it becomes clear the results are as good, if not superior, to those obtained using the standard method of treatment. Furthermore, they are cost effective and require no hospitalization.

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To Charlotte and Jack

Last week I received a telephone call with an insistent demand, "Al, you must write about Charlotte in your medical journal; a photograph of her on the front cover!" I told Jack this could be considered, but that I could make no promises. Jack demanded to know just how much influence I have as editor of *Iowa Medicine*. I assured him that I would do my best to honor the memory of Dr. Charlotte Fisk.

Dr. Fisk was of diminutive stature but was a giant as an influential member of the pediatric staff of Blank Children's Hospital. I came under her influence first as an intern in 1948, continuing through my residency and throughout the years I practiced as a colleague in Des Moines. There was no doubt from the beginning that Dr. Fisk was a champion of the pediatric residents. She had a way of keeping us on our toes, as well as a fervor to make sure the hospital administrator knew that the care of children was to be the highest order of importance. Her major pet peeve was to hear children referred to as "kids".

Dr. Fisk's accomplishments were many. She was an active supporter of the Blank Hospital Guild, she insisted on Guild support of the residency program, she developed a separate library for the pediatrics section, promoted an annual Pediatrics Conference in memory of Dr. Lee Hill and developed the neonatal intensive care unit in 1972.

Charlotte loved children, dogs, sports, nature and life in its fullest measure. Her life quietly came to an end on March 7, 1996.

There is more. That insistent telephone call was from Dr. Jack Spevak. Over the years it was evident that Jack was the consummate student; constantly striving to attain more knowledge. He could be very domineering at times, but with children he was gentle and loving. Each ill child was to him a special challenge.

We of the pediatrics staff were astonished when he left us to enter a hematology training program. But, he came back, and later entered the world of academics in another state. Again, he came back, reestablishing his very active practice until his "retirement" about two years ago. But he never really retired. He continued to study, attend clinical meetings, visit the hospital library and attend classes at Drake University. Dr. Spevak died suddenly while attending a class in Chinese history on April 1, 1996. Little did we know, Jack, when you asked me to write about Charlotte that I would have to include you as well.

You have been a credit to our profession and our mentor.

The medical profession, the children you have served so well and all your friends will miss both of you. Charlotte and Jack, you have been a credit to our profession, our mentors, our friends and our inspiration to be better physicians. IM



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Physicians are no exception to this phenomenon. As many mid-career doctors may be struggling to keep up with their teenage children in the use of computers, our faculty at the University of Iowa College of Medicine are in the same relative position with regard to entering medical students. Within two academic years the use of computers in our curriculum has risen exponentially. Faculty members are developing educational software and students have access to an increasing number of texts, journals and other reference materials via the internet.

Within two academic years the use of computers in our curriculum has risen exponentially.

Now initial on-line continuing medical edueation modalities are emerging. In a project developed within the Department of Pathology at the University of Iowa, physicians can learn about laboratory management while sitting at their personal computer. The program, eventually to be constructed in 20 modules, will enable physicians to acquire the knowledge to be a laboratory director, meeting requirements of the Clinical Laboratory Improvement Act (CLIA). A total of 20 hours of training is necessary.

The course is constructed so that following the completion of each module examination can be taken via computer; the review and scoring of the examination is done by the course organizer. A modest registration fee is charged. The developers of this course, Drs. Ronald Feld, Marian Schwabbauer and John Olson at the University, foresee its considerable potential for community physicians to acquire training at their own pace without the associated expenses of travel, lodging and loss of practice time.

There is considerable effort nationally to develop a full package of electronic interactions so that all elements of the course, including registration, the financial transaction to pay the fee via credit card and scoring with certificate, can be accomplished electronically.

The adventuresome among our readership might want to look at the laboratory on-line course. It is available at the address for University of Iowa's Virtual Hospital home page at *http:\vh.radiology.uiowa.edu.* IM



RICHARD NELSON, MD

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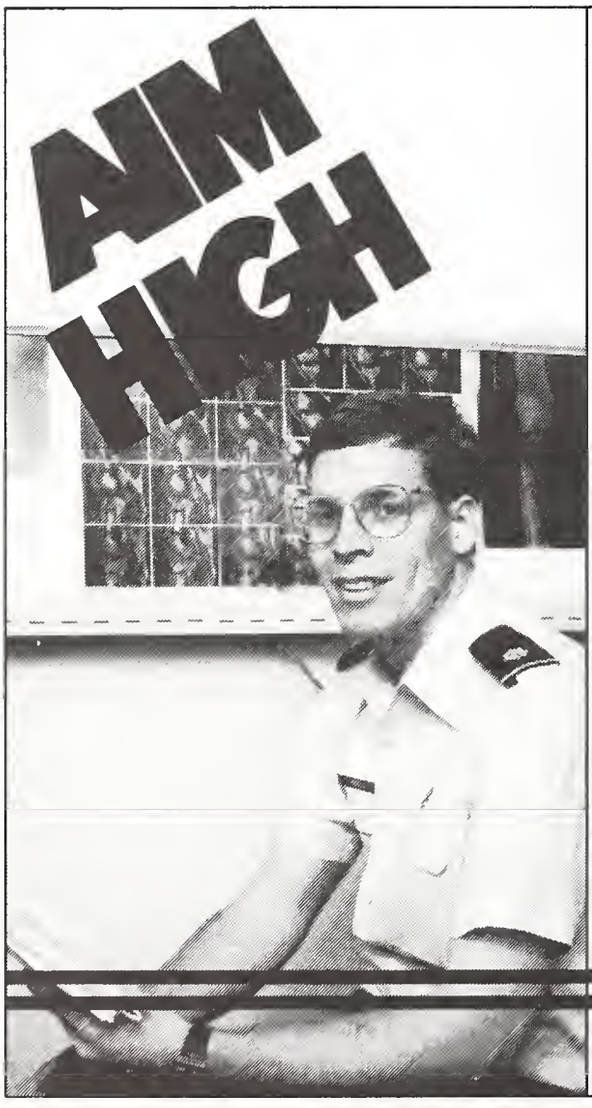
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Fort Dodge 50501
515/576-7777

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Cedar Falls 50613
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214 - 13th Street Southeast
Cedar Rapids 52403
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Robert B. Goffstein, MD
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Lynn M. Lindaman, MD
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Donna J. Bahls, MD
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(Continued next page)

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Fort Dodge 50501
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Fort Dodge 50501
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Michael Witte, DO
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Fort Dodge 50501
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Vascular Surgery

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Marshall C. Hunting, MD
800 Kenyon Road
Fort Dodge 50501
515/574-6865

Urology

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Iowa Medicine

NAL OF THE IOWA MEDICAL SOCIETY | JULY–AUGUST 1996

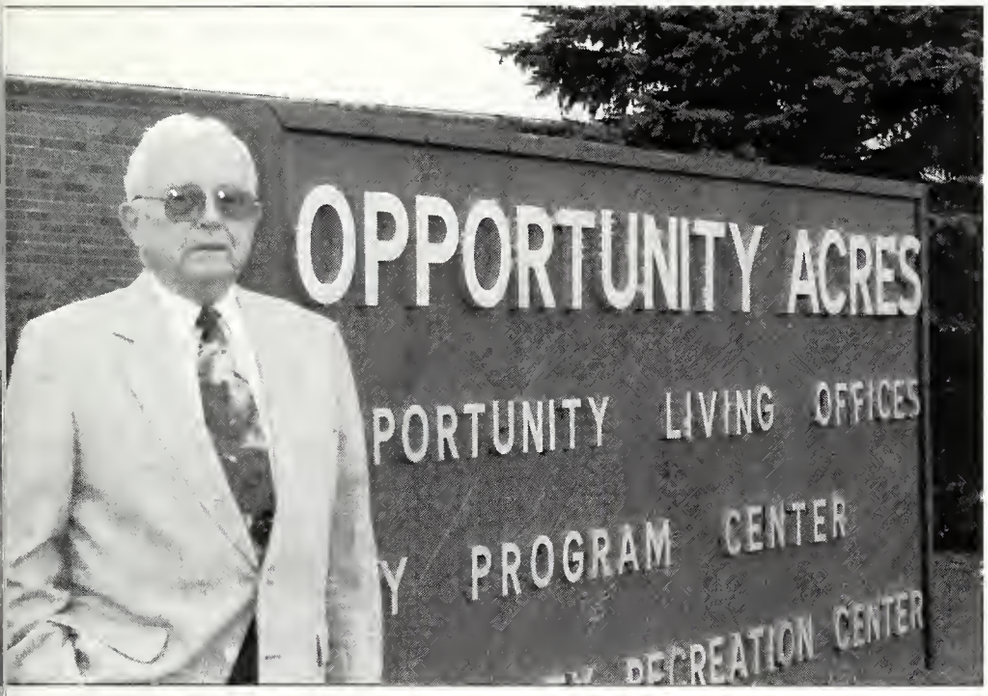
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Iowa Medical Society award winners



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IMS *DEADLINE* news

JULY-AUGUST, 1996

Late-breaking news of interest to Iowa physicians

●**AS OF PRESS TIME, AMA WAS LOBBYING FURIOUSLY** against onerous anti-fraud and abuse provisions in the Kennedy/Kassebaum bill. The provisions, according to AMA President Dr. Lonnie Bristow, would criminalize innocent coding and billing errors. AMA has mobilized a grass roots effort by the nation's physicians, running full-page ads in high-profile Washington newspapers. House and Senate conferees are reportedly being inundated with calls from physicians who don't want to be jailed or excessively fined for innocent mistakes.

●**TWO RECOMMENDED STRATEGIES FOR PREVENTING GROUP B STREP** have been released by the Centers for Disease Control (CDC). As you will recall, during the past session of the Iowa Legislature, IMS representatives were successful in killing legislation which would have mandated testing for group B strep between the 35th and 37th weeks of pregnancy. The CDC recommendations were published May 31 in the *Morbidity and Mortality Weekly Report* (Centers for Disease Control and Prevention, Prevention of perinatal group B streptococcal disease: a public health perspective. *MMWR* 1996; 45 (RR-7):1-24). See the next issue of *Iowa Medicine* for more information.

●**THE IOWA MEDICAL SOCIETY AND ITS STAFF** have won the United Way's Central Iowa Leadership Award for exemplary support of the United Way annual community campaign. IMS won in the category of businesses with under 100 employees.

●**MERIT BEHAVIORAL CARE OF IOWA** the often-in-the-limelight managed care company administering Title 19 mental health benefits in Iowa, has been awarded a four-month extension into the optional third year of their contract. This takes their contract to July 1, 1997. However, the Council on Human Services plans to develop "additional performance specifications" and reassess MBC's performance this September. If the company meets the new specifications, its contract will be extended an additional eight months until March of 1998. If not, MBC's contract will end next July and the contract awarded to another company.

●**IOWA FOUNDATION FOR MEDICAL CARE** has been named the PRO for Illinois. A protest motion filed by a competing bidder has been withdrawn. IFMC is now the PRO for Iowa, Nebraska and Illinois.

●**NONPHYSICIAN PRESCRIBING, THOUGH STILL A TINY PERCENTAGE** of total prescriptions, has more than doubled during the past two years across the country. Physician assistants and nurse practitioners write almost one million prescriptions a month.

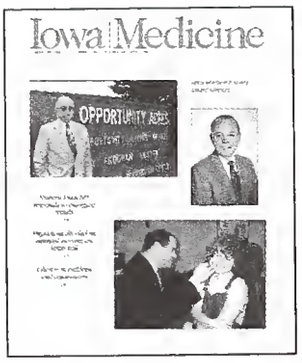
●**IOWA IS THE NATION'S HEALTHIEST STATE,** according to a study by Morgan Quitno Press, an independent private research company. The study measures 23 factors including infant mortality rates, adult smoking percentages, childhood immunization rates and per capita spending on health care. Iowa moved up from No. 8 last year. Arkansas ranks as the least healthy state.

●**IMS STAFF MEMBER PAUL BISHOP,** manager of IMPAC and legislative relations, extends his gratitude to all IMS members who expressed sympathy in the form of flowers, cards and telephone calls. Paul's wife Christina was killed in an auto accident near Anamosa in May. Memorials to Christina are being given to Blank Children's Hospital in Des Moines.

For more information about any *DEADLINE* news item, call Chris McMahon at IMS headquarters, 515/223-1401 or 800/747-3070.

Iowa Medicine

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About the Cover

1996 IMS award winners pictured on this month's cover are (clockwise, from top): Dr. Paul Ferguson of Lake City, winner of the Physician Community Service Award; and Dr. John Anderson of Boone, winner of the Merit Award. Also pictured is Dr. William McMillan of Ottumwa, 1996-97 IMS president.

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EDITORIAL

223 **Detached concern doesn't cut it**

Incoming IMS President William McMillan, MD believes an important part of being a physician is showing your patients that you care. ● *THE PRESIDENT COMMENTS*

For 1996 IMS House of Delegates proceedings, see insert between pages 246-247.

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FEATURE ARTICLES

238 **Physicians divided on assisted suicide**

The AMA says the U.S. Constitution does not grant Americans the right to be "killed by their physicians". Yet, a poll of 500 Iowa physicians shows them narrowly split on the issue of assisted suicide. Look inside for more on the survey results, comments from responding physicians and the latest from the AMA on its strong stand against physician-assisted suicide.

241 **How can you help overweight patients?**

A surprising number of Iowans are overweight. In this guest article, a registered dietician says many of these patients will deny the negative effects of excess weight unless their physicians tell them it is a concern. ● *KATHY RUEVE, RD*

Patients are asking Iowa physicians for dexfenfluramine, the latest diet pill. In next month's issue, a physician who is a weight loss expert advises physicians who wonder what to tell them.

SCIENCE AND EDUCATION

243 **Obesity in children and adolescents**

The prevalence of obesity in children and adolescents is increasing. The only treatment that has been shown to be successful is a multidisciplinary family approach with long-term follow-up. ● *JENNIFER COOK, MD; RAYNA GROTHE, MD*

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Detached concern doesn't cut it

There are many forces challenging the practice of medicine, some of which threaten the quality of medical care. Physicians feel uncertain, even fearful about the future. While this is understandable in the face of so much change, there is a way to keep our profession viable and bring Iowa's physicians together to share a vision which will carry us into the next century.

Despite powerful economic and social transformation, we must rekindle a sense of community responsibility and service to others. The way to face these problems in our nation is by investing in her people. Healthy towns, healthy jobs, healthy families and healthy minds and bodies are the engines that drive us to success, happiness and long life.

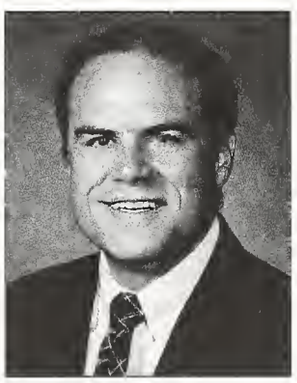
While medical ethics must remain centered around the individual patient, our profession can concentrate on a broader social contract. We must empower each physician with the ability to determine their own self worth in terms of service and fulfillment, honor and respect, humility and satisfaction. Once we set our worth by someone else's system of values, we lose our own values.

Patients don't care how much you know until they know how much you care.

The bottom line, of course, is the trust of our patients and of our colleagues. Dr. James Todd, former executive vice president of the American Medical Association, summed up the emerging threats to patient care and the medical profession in this way—"With the government's failure to lead the country in health care reform, it is occurring spontaneously in the worst possible fashion, with unbridled cutthroat competition." The strength of our profession lies in our pledge to be there when we are needed for our patients and for each other.

To stand by and do nothing while this pledge is threatened is unethical. To allow aggregate overcharging to satisfy corporate bottom lines or maintain inefficient or ineffective facilities imposes barriers for all of us. Physicians must help insure that managed care plans are held accountable for the public health and cannot be allowed to operate as single-minded fee collectors.

In this mix of personal, professional and public responsibility we must maintain trust in each other, mutual respect, self restraint and shared goals. We can only earn the public trust through service. Which means standing for the rights of our patients and peers and against those who would use us badly. We must stand up for availability, affordability, accessibility, acceptability and affability. We must comfort the afflicted and afflict the comfortable. We have more than a job, a career or a profession—we have a calling. Constructive involvement in our community reflects this calling at its best. Detached concern doesn't cut it anymore. Patients don't care how much you know until they know how much you care. IM



WILLIAM MCMILLAN, MD

EDITOR'S NOTE
Dr. William McMillan gave this speech to the Iowa Medical Society House of Delegates on Sunday, April 21 following his inauguration as 1996-97 IMS president. Dr. McMillan is an otolaryngologist practicing in Ottumwa.

What's Important Here?







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Eastern Iowa IPA responds to emerging trends

In 1980, recognizing an emerging trend toward managed care, Scott County physicians organized the Independent Physicians' Association of Eastern Iowa, one of Iowa's first IPAs. The IPA now operates as the Great Plains Physicians Group.

Since its beginning, the organization has endeavored to give customers provider networks which include physicians and facilities located throughout the Iowa and Illinois Quad Cities.

In 1993, the IPA of Eastern Iowa gave birth to Comprehensive Health Administration (CHA) as its administrative support and marketing organization. CHA provides managed health care and third party administrative services to employers and a variety of services to IPA physicians.

CHA markets provider networks

CHA also markets Advantage Health Plan, a PPO created in 1992. The Advantage Health Plan is one of several provider networks marketed by CHA to employers, third party administrators, insurance carriers and managed care organizations. Other CHA provider networks include a Quad City panel, a Title XIX panel and Work Comp Services.

The composition of the panels include many of the same physicians. However, there are subtle differences.

Advantage Health Plan includes about 400 providers, an equal number from each side of the river. The network includes physicians who are members of the IPA of Eastern Iowa and those who are not members. All specialties in the Quad Cities are represented.

The **Quad Cities Panel** includes over 360 physicians. All participants are members of the IPA; physicians who practice primarily in Scott County comprise a large portion of the panel.

Work Comp Services is a managed workers' comp program which helps physicians meet the needs of employers through application of managed care skills. The program involves a bi-state network of 230 primary care and specialty physicians, an injury and care management tracking system, case managers and treatment protocols.

CHA also provides administrative support to an independent network of ophthalmologists and optometrists.

CHA offers variety of services

CHA expands a provider's contracting capabilities through development of provider networks tailored to customer needs. Currently, about 34,000 people have contractual access to one of CHA's provider networks. CHA offers clients services including:

- Development and management of physician networks.
- Reimbursement guidelines.
- Provider credentialing.
- Development and implementation of utilization and quality management policies and review criteria for inpatient, outpatient and office-based care.
- Utilization review for inpatient, outpatient and office care for covered persons.
- Analysis of data by the IPA's medical director and quality assurance committees.
- Ongoing education and intervention with providers.
- Preparation of utilization and savings reports.

CHA offers provider support services including temporary employee staffing, electronic claims submission, practice management software and managed care contract review.

According to Michael Krach, chief operating officer, CHA also operates as a kind of "laboratory" for the trial of innovations such as electronic eligibility verification. Utilization review, credentialing and third party administrative services are now being offered to other physician-oriented networks through CHA.

"Strategic and long-term planning are ongoing activities for CHA and the IPA of Eastern Iowa," he says. "We hope to strengthen our quality management abilities and align with other like-minded health care organizations to create electronic communications and data management infrastructure to support on-line, real-time transmission of information." IM

CHA has contractual relationships with other Quad Cities health care providers and facilities to create customized networks.

KEY CONTACTS:

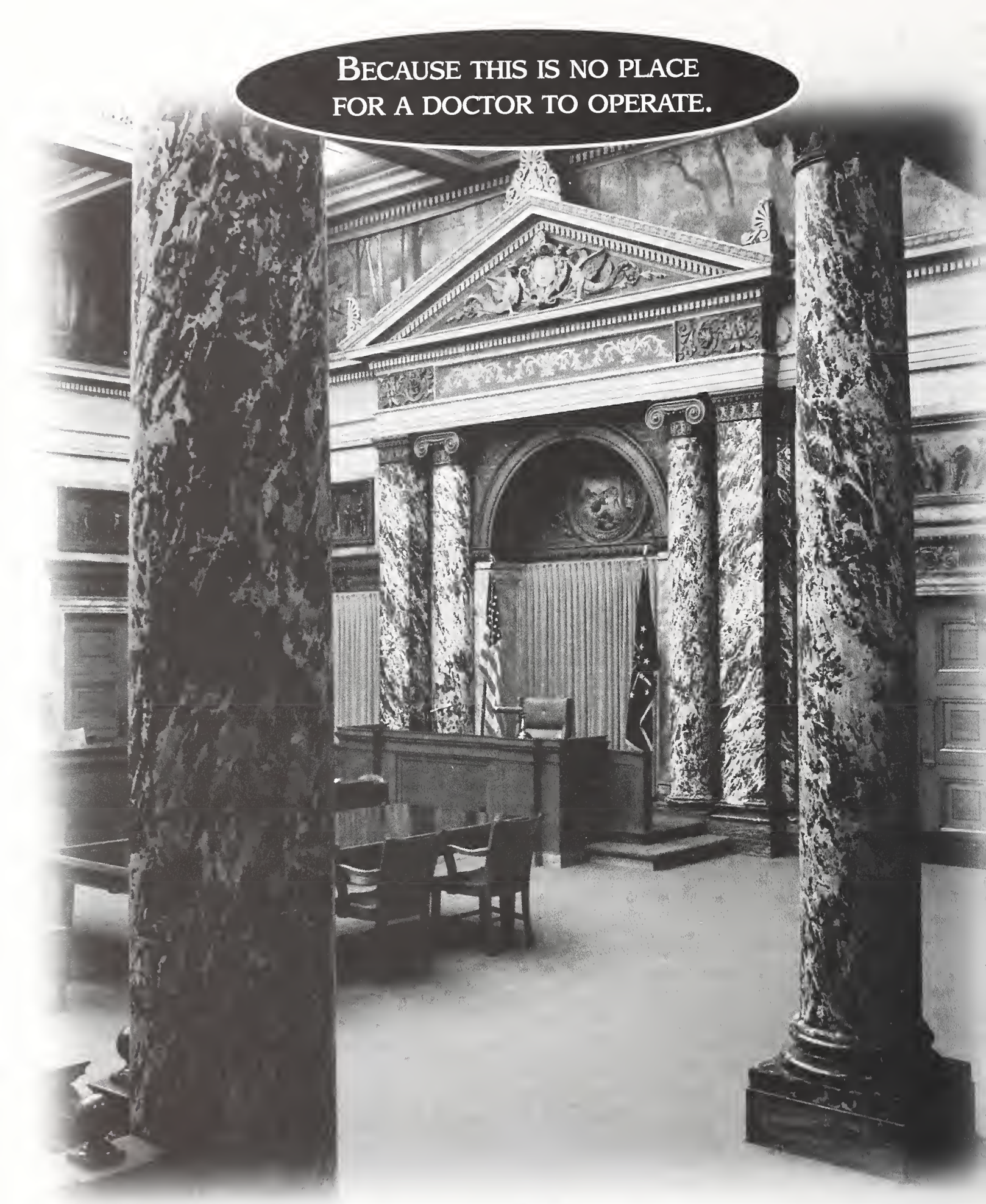
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president, IPA of Eastern Iowa
319/383-2763

Amir Arbisser, MD
president, CHA
319/323-8888

William Langley, MD
medical director, IPA of Eastern Iowa
319/324-2460 ext. 215

Michael Krach
CHA
chief operating officer
319/324-2460 ext. 204

This month's story is the second of a series of articles on how various practice groups in Iowa plan to cope with the future. If you know of other arrangements controlled by physicians and positioned to compete in the managed care market — call Barb Cannon or Chris McMahon at the IMS, 515/223-1401 or 800/747-3070.



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IMS Update

Please return your verification letter

July 12 is the deadline for returning your IMS member verification letter. The letter — sent to all IMS members in early June — verifies member information for IMS records and the 1996-97 IMS Membership Directory. It is important that you return your letter to ensure the correct information about your practice appears in the IMS Directory.

The 1996-97 IMS Membership Directory will be published in October.

Family physicians win IMS awards

John Anderson, MD, a family physician from Boone, was the recipient of the Iowa Medical Society Merit Award at the IMS annual banquet Saturday evening, April 20 in Des Moines. Dr. Anderson has held numerous IMS offices, including serving as president in 1993-94. He is a longtime delegate to the AMA and has served on the Iowa Board of Medical Examiners.

Also at the banquet, Paul Ferguson, MD, a family physician in Lake City, received the IMS Physician Community Service Award.

IMSA "Baby Think It Over" campaign

The IMS Alliance has purchased two "Baby Think It Over" dolls which are available for loan to any IMS member physician.

According to IMSA President Karen Messamer, the dolls are infant simulators which command attention.

"Through this project, the IMSA wants to help stop the cycle of poverty and lost dreams caused by teenage pregnancy," she explains.

For more information about the campaign or to borrow a doll, call Sandy Nichols at the IMS, 515/223-1401 or 800/747-3070.

continued

AT A GLANCE

Thank you to all the members of the IMS Executive Council, county society presidents, IMS committee chairs and others who answered a recent survey regarding qualifications and qualities in the new IMS executive vice president. Eldon Huston, current IMS executive vice president, is retiring at the end of 1996. The survey was part of the search process currently underway at the direction of the IMS Board of Trustees.

David Lyons of Des Moines was the recipient of the 1996 John F. Sanford Award of the Iowa Medical Society. The award honors lay individuals for outstanding contributions in the health care field. Mr. Lyons, chairman of the Iowa Health Care Reform Council, was honored for his dedicated leadership in making Iowa a recognized leader in health care reform.

NEWS FROM IMGMA

Clinic managers' project focuses on simplifying physician credentialing forms

After months of hard work, software is available to help in completion of physician credentialing forms. This software was the topic of discussion when the IMGMA Legislative Committee met recently with insurance industry representatives. The software — which runs on Windows 3.1 and is available through the IMGMA — will be a valuable tool in clinic management.

Blue Cross Blue Shield has agreed to accept this credentialing form and other companies anticipate aceepting it in the near future. The form is 12 pages long; some insurance companies may require an additional single sheet attachment.

Credentialing software is very easy to use and will save hours of duplication in a medical practice. Data ean be stored on a computer and printed on demand. (Remember that copies of licenses and certificates will need to be attached to the form and sent to various agencies upon their request.)

The IMGMA plans to continue working with any insurance company interested in this credentialing form. We also hope to generate interest in this project among Iowa hospitals.

This credentialing form will be adaptable to MSOs, PPOs, PHOs or any other managed care organization, thus streamlining the credentialing process for clinic managers.

The most satisfying aspect of this project is the fact that we achieved our goal — administrative simplification for clinic managers — without legislation. An important side benefit in this project is the excellent avenue of communication we have opened with insurance companies.

This article focusing on an important project of the Iowa Medical Group Management Association was written by Pat Buelow, administrator for Linn County Urology and chair of the IMGMA Legislative Committee.

IMS Update

continued

Specialty Society Update

Newly-elected Board of Directors for the Iowa Society of Rehabilitation Medicine are: Marvin Hurd, MD, Des Moines — president; Fareeduddin Ahmed, MD, Davenport — vice president; Paulette Lynn, MD, Dubuque — secretary/treasurer; Jill Meilahn, DO, Des Moines — representative to the American Association of Physical Medicine and Rehab; Richard Mosher, MD, West Burlington — board member.

The board of the American College of Cardiology, Iowa Chapter met in conjunction with the IMS House of Delegates and will meet July 27 in Davenport in conjunction with the Bix Beiderbecke Jazz Festival. "Cardiology at the Bix" is sponsored by Genesis Medical Center.

Mark Preston, MD, Des Moines, is the new chair of the Iowa Psychiatric Society Legislative Committee. The Mental Health Advocacy Coalition continues its efforts. The Iowa Division of Insurance has filed a proposed rule increasing to $50,000 the lifetime limit for mental health benefits under the standard small group insurance plan. This rule filing is the result of the Coalition's efforts. IPS members have also been writing to congressional leaders regarding parity for mental health benefits. The national publication *Mental Health Weekly* ran a two-part feature on the Iowa Mental Health Access Plan. IPS members were widely quoted in the article.

Nearly 500 people attended the Iowa Medical Group Management Association 12th annual Spring Education Program at the Des Moines Marriott in May. Jacque Sokolov, MD, a California cardiologist and noted national expert on integrated physician organizations, was the keynote speaker. The IMGMA fall meeting will be Sept. 18-20 at the Davenport Radisson.

The American Medical Directors Association, Iowa Chapter, is working with its national organization on the issue of nursing home standards. Congress is considering eliminating the Medicaid block grant requirement that nursing home facilities have an MD or DO as medical director. IM

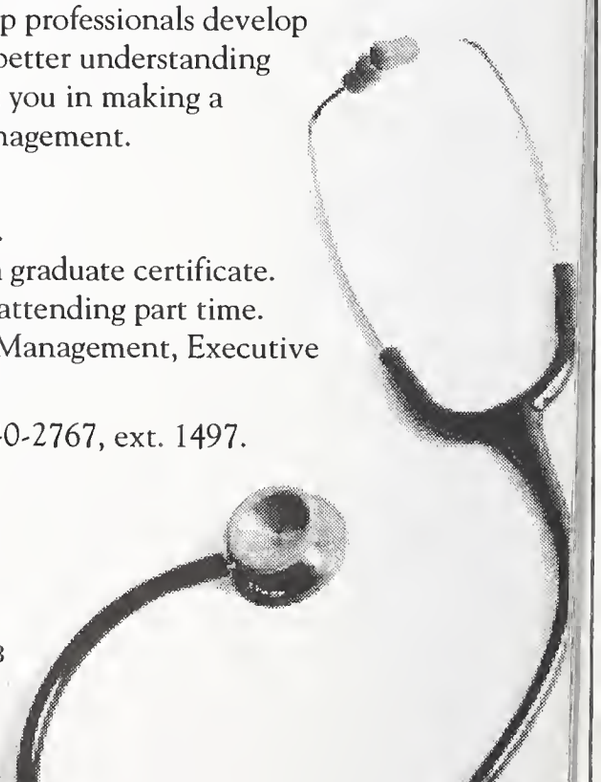
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Legislative Affairs

1996 Voting Records

While the 1996 legislative session was a busy one for IMS there were few actual votes on specific issues. Much lobbying time was spent convincing legislators not to bring up bills such as legislation setting protocols relating to management of group B streptococcus and several any willing provider bills. Most of the bills that were brought to votes by the House and Senate had significant support so the voting records show little controversy over the final version. (Legislative leaders are reluctant to bring bills up for debate until most problems have been worked out.)

Voting records are only a tiny part of a legislator's record on issues. Many legislators provide significant assistance behind the scenes working in support of the IMS position. Other legislators work in opposition to the IMS point of view. These activities are frequently more important than the actual vote on a bill. Call Paul Bishop of the IMS staff for information on how your state senator and representative worked with IMS lobbyists in 1995 and 1996 and their positions on key issues that were not brought up for votes. Please note that an occasional absence by a legislator is not significant. Legislators may miss a vote because of illness or meetings with constituents.

Physician Assistant Payment—HF 2144

HF 2144 requires third party payers to pay for services provided by physician assistants if the same service would be paid for if provided by a physician. The IMS opposed this legislative mandate.

HOUSE

Ayes: 88

Arnold, Baker, Bell, Bernau, Blodgett, Boddicker, Boggess, Bradley, Brammer, Brand, Branstad, Brauns, Burnkhorst, Burnett, Cataldo, Cohoon, Connors, Coon, Corbett (Spkr.), Cormack, Daggett, Dinkla, Disney, Doderer, Drake, Drees, Eddie, Ertl, Fallon, Garman, Gipp, Greig, Greiner, Gries, Grubbs, Hahn, Halvorson, Hammitt Barry, Harper, Harrison, Heaton, Holveck, Houser, Hurley, Huseman, Jochum, Klemme, Koenigs, Kreiman, Kremer, Lamberti, Larkin, Lord, Main, Martin, Mascher, May, McCoy, Mertz, Meyer, Millage, Moreland, Mundie, Murphy, Myers, B. Nelson, L. Nelson, Nutt, O'Brien, Ollie, Osterhaus, Renken, Salton, Schrader, Schulte, Shoultz, Siegrist, Sukup, Taylor, Teig, Thomson, Tyrrell, Van Fossen, Veenstra, Warnstadt, Welter, Witt, Van Maanen, Presiding

Nays: 8

Carrol, Churchill, Grundberg, Hanson, Jacobs, Metcalf, Vande Hoef, Weidman

Absent or not voting: 4—Larson, Rants, Weigel, Wise

SENATE

Ayes: 47

Banks, Bartz, Bennett, Bisignano, Black, Boettger, Borlaug, Boswell, Connolly, Dearden, Deluhery, Douglas, Dvorsky, Fink, Flynn, Fraise, Freeman, Gettings, Giannetto, Gronstal, Halvorson, Hammond, Hansen, Hedge, Horn, Husak, Iverson, Jensen, Judge, Kibbie, Lind, Lundby, Maddox, McKean, Murphy, Neuhauser, Palmer, Priebe, Redfern, Rensink, Rife, Rittmer, Sorensen, Szymoniak, Tinsman, Vilsack, Zieman,

Nays: 1—Drake; Voting present: 1—Kramer; Absent or not voting: 1—McLaren

Enhanced Penalties for Assaulting Emergency Workers—SF 2167

Increases penalties for assaulting emergency workers in hospitals. (Similar enhanced penalties are already provided for law enforcement officers and emergency workers outside hospitals.) The IMS strongly supported this bill.

SENATE

Ayes: 49

Banks, Bartz, Bennett, Bisignano, Black, Boettger, Borlaug, Boswell, Connolly, Dearden, Deluhery, Douglas, Drake, Dvorsky, Fink, Flynn, Fraise, Freeman, Gettings,

continued

AT A GLANCE

In an editorial in the Des Moines Business Record, *State Rep. Janet Metcalf discussed the legislature's handling of the maternity stay controversy. She said of the bill which eventually passed, "We have put the decision squarely where it belongs: with the doctor, in consultation with the mother; not in the hands of the insurance companies or the legislature."*

A new feature, "Rate Your Rep", is being offered on the World Wide Web by Congressional Quarterly. *Net surfers can see if they agree with House and Senate members on issues. See "American Voter '96" on the World Wide Web . . . http://voter96.cqalert.com.*

The Insurance Commissioner is appointing a small work group to develop rules implementing the maternity care legislation. At least two physicians will participate.

Legislative Affairs
continued

Giannetto, Gronstal, Halvorson, Hansen, Hedge, Horn, Husak, Iverson, Jensen, Judge, Kibbie, Kramer, Lind, Lundby, Maddox, McKean, McLaren, Murphy, Neuhauser, Palmer, Priebe, Redfern, Rensink, Rife, Rittmer, Sorensen, Szymoniak, Tinsman, Vilsack, Zieman

Nays: 1—Hammond

HOUSE
Ayes: All except 1 absent; Nays: None; Absent or not voting: Eddie

CHMIS Delay—SF 2218

Delays implementation of phase I of the Community Health Management Information System for one year, until July 1, 1997. The IMS supported this bill.

SENATE
Ayes: All; Nays: None

HOUSE
Ayes: All except 3 absent; Nays: None

Absent or not voting: 3—Bradley, Main, Salton

Maternity Care—HF 2369 (final version)

Requires the insurance commissioner to adopt rules requiring third party payers subject to state regulation to pay for post-delivery hospital care as determined medically appropriate by the attending physician in consultation with the patient based on Guidelines for Perinatal Care issued by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. The physician is protected from adverse utilization review decisions when the ACOG/AAP Guidelines are followed.

HOUSE
Ayes: 96 (All voted yes except for 4 not present.)

Nays: None

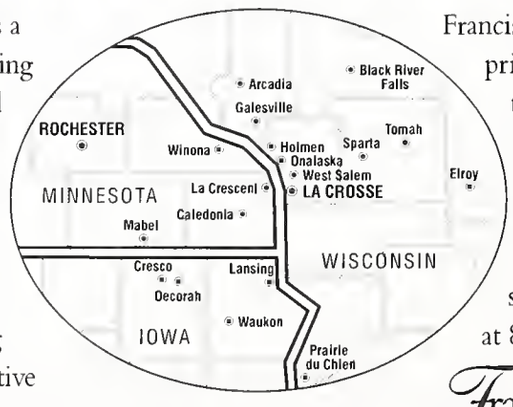
Absent or not voting: 4—Brammer, Myers, Salton, Veenstra

SENATE
Ayes: 49 (All voted yes except for 1 not present.)

Nays: None; Absent or not voting: Banks IM



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Medical Economics

Quad Cities cited as top market

In a survey by a Texas-based recruitment firm, the Quad Cities area was identified as one of the top 10 employment markets for physicians. Criteria to be listed as one of the top 10 opportunity markets for physicians include "a clearly demonstrable need for physicians, the availability of relatively favorable practice conditions and favorable prospects for future practice growth."

Other top 10 markets are eastern Washington State; Evansville, Indiana; Fargo, N. Dakota; Springfield, Mo.; the Mississippi Gulf Coast; north central Florida and its panhandle; southern California and west Texas.

CHMIS Board wants legislative debate

Possible legislative financing of CHMIS and dissolution of the Iowa Health Data Commission (IHDC) headed the agenda at a recent meeting of the CHMIS Governing Board.

The IHDC was scheduled to dissolve on July 1, 1996 with implementation of CHMIS. CHMIS implementation has been delayed one year, creating a one-year gap in data that IHDC collected and what CHMIS was designed to collect.

The CHMIS Board now says it has the authority to collect the same data the IHDC has been collecting from hospitals and payers.

The Board also faces financing issues since the grant from the Hartford Foundation expires on June 30, 1996. Key stakeholder groups including the Iowa Medical Society are being solicited for one-time contributions to fund CHMIS through June, 1997. CHMIS Board members plan to ask the 1997 Iowa Legislature for $250,000 for operating funds.

This is a significant departure from language in the current CHMIS law, which called for CHMIS to be self-supporting through usage fees paid by providers and others. The Governing Board's position is that the value of CHMIS to the public should be debated by the legislature. If it is deemed to be of value, the public should pay for it. If not, the Governing Board would be forced to view it as lack of public support and consider ending the project.

At the Governing Board meeting, an implementation plan was approved which calls for CHMIS to set standards for submission of various electronic health care transactions. The plan also outlines how CHMIS will access data in proprietary data bases. The Association of Iowa Hospitals and Health Systems will donate its inpatient and outpatient data bases to CHMIS, as it has for IHDC.

Sheila Gregan, project manager for CHMIS, planned to resign at the end of June and a search is on for a replacement.

Finally, three new CHMIS advisory committees will be appointed — Standards, Data Reporting and Ethics and Confidentiality. A

continued

1996 Medicare Participation for selected Iowa specialties

Specialty	# of New Par	1996 Par Percent
Anesthesiology	38	91.5%
Cardiology	30	95.4%
Dermatology	13	87%
Diagnostic Radiology	51	77.1%
Emergency Medicine	58	95.1%
Family Practice	139	89%
General Practice	18	91.1%
General Surgery	42	91.6%
Internal Medicine	97	95.4%
Neurology	18	96.2%
Obstetrics/Gynecology	26	94%
Ophthalmology	29	92.8%
Orthopedic Surgery	23	93.6%
Otolaryngology	16	94.4%
Pathology	11	92.6%
Pediatrics	30	80.4%
Psychiatry	29	91.7%
Urology	12	83.8%

AT A GLANCE

Medical costs for car crash victims not wearing seat belts average $5,000 more per person than for belted victims, according to a new seven state survey.

According to a recent article in the Wall Street Journal, *an increase in the number of patients taking HMOs to court could signal a revolt against cost-conscious medicine. More and more people are suing HMOs if they perceive they have received inadequate care. In many cases, claims are settled through an internal appeals process or arbitration.*

The House Joint Committee on Taxation predicts one million mostly middle class Americans would sign up for medical savings accounts if they were available.

Medical Economics
continued

fourth advisory committee may be established to recommend CHMIS law changes to the 1997 Iowa Legislature.

Any physician or IMGMA member who wishes to serve on any of these committees may contact Ed Whitver at the IMS, 515/223-1401 or 800/747-3070.

Feds get new weapons to fight fraud

The federal government's war on Medicare fraud and abuse could soon get tougher, experts warn.

The federal government's war on Medicare fraud and abuse could soon get tougher, experts warn. The Kassebaum-Kennedy bill contains a little-known provision that would give new weapons and more money to federal law enforcement officers.

The bill would create six new federal criminal offenses and expand from two to three the categories of mandatory exclusion from participation in Medicare and Medicaid.

The bill has passed both houses of Congress. Currently, a committee is working to resolve differences between the House and Senate versions of the bill. IM

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Practice Management

Denial of truncated codes begins July 1

Blue Cross Blue Shield will start denying Medicare claims with truncated ICD-9 codes as of July 1. Truncated codes are those without appropriate fourth or fifth digits. There will be no right to appeal on these denials but the claim can be corrected and resubmitted.

Incomplete ICD-9 CM codes are the leading delay in Medicare claim processing in Iowa. The new policy is part of a national effort by HCFA required by OBRA '88. Nonassigned claims will be suspended and developed for the accurate code.

To avoid errors, physicians should use the 1996 ICD-9-CM code book, which is updated annually. It is available from the AMA at 800/621-8335.

HCFA conducts five-year review of RVUs

Following is an update on the progress of two important HCFA projects:

•Five-year review of work relative value units — A proposed rule has been released for clearance and the final rule should be out in November. In the Notice of Proposed Rulemaking, HCFA proposes changes in the 1997 RBRVS as a result of public comments it received in early 1995. Comments covering about 3,500 codes were referred to the AMA's Specialty Society RVS Update Committee (RUC) for review.

Major changes proposed as a result of these recommendations include significant increas-

continued

AT A GLANCE

The federal government recommends that doctors routinely ask patients about their tobacco use and work to get smokers, chewers and sniffers to quit. At least 70% of tobacco users see a physician each year; 50% see a dentist. Physicians and dentists aren't taking advantage of these opportunities, says the Agency for Health Care Policy and Research.

Diane Marshall, office manager for Dr. Randall Maharry, Des Moines, received the Iowa Medical Society's Outstanding Office Administrator Award at the IMS Annual Banquet in April. Ms. Marshall has worked in Dr. Maharry's office for 21 years and is past president of the state chapter of the American Association of Medical Assistants. She is on the advisory committee to the IMS Medical Business Specialist program.

MIDWEST MEDICAL INSURANCE COMPANY • FOCUS ON RISK MANAGEMENT

Documentation after a bad outcome

Your patient was scheduled for a right knee arthroscopy with anterior cruciate ligament reconstruction, but after the incision was made and the knee entered, you realize that you just operated on the wrong knee. You proceed with surgery on the correct knee, but what do you chart in the medical record?

After discussing the event with the patient and family, complete and accurate documentation of the procedure(s) should be done immediately. There have been cases where physicians have neglected to document the procedure for several weeks or months. Then, in error, they dictate a "canned" operative report and sign it without reading it. Only after the malpractice claim has been filed and they are deposed do they realize the significance of the lapse in memory.

Conversations with the patient and family explaining the situation and the plan should be documented objectively. Do not place blame, point fingers or apologize in the medical record. Do not document that the liability insurer or risk manager was contacted.

After a physician receives notice that a patient has filed a malpractice claim due to a bad outcome, often the first impulse is to review the medical record. After the review, the physician may feel the documentation is not as complete or clear as it should be. The physician might be tempted to make innocent additions or corrections to reflect more clearly the care that was provided.

Do not alter or make additions to the record after a bad outcome or notification of a claim. The additions or corrections can and will be detected and appear self-serving. These changes can be viewed as an attempt to cover up mistakes and will weaken your defense. Discuss concerns regarding your documentation with your insurance claim representative or attorney. It's much easier to explain incomplete or unclear documentation at deposition than to explain embarrassing additions made after the fact.

For further information, contact Lori Atkinson, MMIC risk management supervisor, MMIC West Des Moines office, PO Box 65790, West Des Moines, Iowa 50265, 800/798-9870 or 515/223-1482.

Practice Management
continued

es in the codes for evaluation and management visits and consultation services, gynecology services, general and vascular surgery. The AMA committee successfully defended the current relative values for urology and radiology services after commenters suggested they might be valued too high. HCFA is proposing higher relative values for about 4% of the CPT codes and lower values for about 2%. The new values proposed in the rule are scheduled to go into effect January 1, 1997.

•Development of resource-based practice expense relative value units — New values are scheduled to go into effect for 1998. Over $15 billion is at stake under the fee schedule with this project. The expert panel reviewing the survey results met in June and HCFA hopes the data files will be available in the fall.

The data should be made public and a final rule is scheduled for the fall of 1997. IM

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Wabasha	Five physicians	2,384
Wisconsin		
Tomah	Four physicians	7,570
Menomonie	19 physicians	13,000

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Call IMGMA office for information—800/747-3070 or 515/223-1401
Registration materials will be mailed to IMGMA members in July

Newsmakers

AT A GLANCE

The UI Hospitals and Clinics Medical Museum has opened a new exhibit entitled "Order and disorder: An exploration of the mind and the brain". Symptoms and current treatment of mental illnesses are graphically explored by the museum. The exhibit gallery is located on the eighth floor of the John Colloton Pavilion at the UIHC and is open from 1–4 p.m. weekends and 8 a.m.–5 p.m. weekdays.

Seven Iowa physicians are among those featured in a new book entitled An All American Medical Hall of Fame. *The 160-page volume is a tribute to men and women who were judged to have made significant contributions to advances in the art and science of medicine in the last two centuries. The members selected were also to be deceased. They are: Walter Bierring, MD; Rubin Flocks, MD; Arthur Steindler, MD; Arthur Erskine, MD; Dean Lierle, MD; Henry Minthorn, MD and Rudolph Kampmeier, MD.*

Letters to the Editor

"Managed care in Iowa"

Dear Editor:

Thank you for the short article entitled "Managed care in Iowa" in the Managed Care, News You Can Use section of the March issue of *Iowa Medicine.*

It is not easy being a representative for the variety of physicians in a whole state sueh as Iowa. This objective information, however, is extremely important to most physicians in Iowa. And, it is often problematic to obtain the information as an individual physician. I applaud you for making this pertinent information available. As the state society for Iowa physicians, you perform a valid and important function when you support physicians and their patients by making all concerned more knowledgeable. Thank you again and keep up the good work.—*Michael Hart, MD, Des Moines.*

"To Charoltte and Jack"

Dear Editor:

The tribute "To Charlotte and Jack" by Dr. Marion Alberts in the May–June issue of *Iowa Medicine* was heartwarming. Both physicians added so much to the medical profession and to the patients they served.

We in Polk County appreciate your comments about both of these outstanding physicians.—*Kathie Lyman, executive director, Polk County Medical Society.* IM

PHYSICIAN SENIOR MANAGEMENT LEADER

Covenant Health System

Covenant Health System (CHS) is seeking candidates to provide leadership in systems which improve individual and collective outcomes for those served by CHS. The physician leader will be part of a 5-person management team which includes the president. This team constitutes the senior leadership for CHS.

The physician leader is responsible for the development of the Population Health Management System as part of the design for managing current and future health care services, known as Community Based Individually Coordinated Care (CBICC). The leader's role is to inspire shared understanding and commitment to Covenant Health System's mission, vision and values; to understand the Population Health Management System's role and integrate it into the larger CBICC system. For the medical staffs, the leader will direct the personnel assigned to support elected medical staff leadership in carrying out functions under the bylaws, rules and regulations. The leader is expected to commit to the management tenets, lead fundamental change efforts, identify and model the role and participate in community activities as a representative of Covenant Health System.

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❖ ❖ ❖

If you are interested in more information or wish to submit a CV for consideration, please contact: Julia A. Marcuzzo, PHR, Employment Coordinator or Janice Yagla, Physician Placement Coordinator, Covenant Medical Center, 3421 W. 9th Street, Waterloo, IA 50702; phone: 319/291-3501; fax 319/236-4048. EOE/Drug Screen Required.



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IMS, Des Moines Register *conduct Iowa poll*

Physicians divided on assisted suicide

A recent poll shows Iowa physicians narrowly split on the issue of assisted suicide, with 51% against and 49% in favor of it in under certain conditions. Those opposed say it undermines public trust in physicians; those who support it say it is the most caring thing a physician can do when hope is gone.

The survey was mailed to 500 randomly-chosen physicians, but it's logical to assume the results would have been the same if every physician in Iowa had participated. The survey — conducted by the IMS and the *Des Moines Register* — garnered 250 responses and showed that Iowa physicians are almost evenly split on the subject of physician-assisted suicide.

In the anonymous survey, 51% of physicians said they oppose assisted suicide; 49% said they favor it. Most of those who support the practice have strong opinions about the conditions which make it acceptable.

A matter of definition

Nine physicians said they have helped someone commit suicide or know of an Iowa colleague who has. Several physicians said they may have prescribed pain medication which led to someone's death, but that their only intent was to relieve pain.

"I would never intentionally take a patient's life, but strive to control pain. If they die in the proeess, this must be accepted as a eomplication," said one.

Another respondent raised the issue of how the term is defined. The public generally understands assisted suicide to involve a physician taking an active role in helping a patient commit suicide. If withholding of life-sustaining procedures and heavy doses of analgesics are counted in the definition, "I have probably expedited some deaths," the physician admitted. (However, legally and ethically, there is a definite distinction between withholding of life-sustaining procedures and physieian-assisted suicide.)

"If they die in the process (of contolling pain), this must be accepted as a complication."

Acceptable conditions

The survey listed several conditions under which assisted suicide is acceptable, including a diagnosis of terminal illness and mental eompetence. Physicians in favor of assisted suieide made these comments:

"Patient must be in a persistent vegetative state and the family must request."

"Terminally-ill, in pain and mentally competent."

"Two MDs, a psychiatrist plus a non-medical person must concur."

"Decision should be made by physicians who are personally involved with the patient's care."

"I think it should be permitted in cases carefully reviewed by a panel other than the physieians doing the procedure. However, I would not do this."

'Don't cross the line', advises AMA

The activities of Jack Kevorkian have fueled continuing public debate about physician-assisted suicide and an increased public awareness of end-of-life issues. While the American Medical Association has taken a very strong stand against physician-assisted suicide, it is obvious that many people — including a significant number of physicians — don't agree with this position. The AMA has provided the following information on its position in a Question and Answer format.

What is the AMA's overall position on physician-assisted suicide?

Physicians are devoted to healing and to relieving suffering. Physicians eannot be the cause of death or assist someone in causing their own death.

Does the AMA's Code of Ethics represent all physicians?

Like all people, physicians have a range of personal opinion. However, the Code of Medical Ethies, maintained by the AMA Council on Ethieal and Judicial Affairs, is widely followed throughout the country. It is cited regularly by state medical boards when determining standards of practice for the medical profession.

How does AMA respond to critics who say this position on physician-assisted suicide does not consider patient fear and desire for dignity at the end of life?

Fear assoeiated with physical suffering, with losing control, with being a burden to or dependent upon family members is an understandable reality. The medieal profession has not concentrated on these issues to the necessary degree. We feel the appropriate alternative to physician-assisted suicide is improved care through a better informed medical profession and public, working together to ease the dying process. Physicians should use all their skills and knowledge to relieve suffering and help patients come to terms with death.

How does the AMA distinguish between controlling pain, even if it causes death, and assisted suicide?

The distinction is based on the intent of the physician's actions. The physician is acting in the best interests of a patient even if, while attempting to eontrol suffering and maximize eomfort, death is hastened. If the physician's intent goes beyond comfort, the physieian is either assisting at suicide or performing euthanasia, both of which are unethical.

How does suicide through pain medication differ from death caused by removal of life support?

In the case of a patient whose life is extended by technology, the patient and family—in consultation with the physician—may decide to withdraw that support. The patient's ability to remove the technological barriers to natural death is paramount to their autonomy.

What about a recent court decision that physician-assisted suicide is a constitutional right?

Nowhere in the Constitution does it state that individuals have a right to have their physicians kill them. No court ruling can change the ethics of the medical profession.

Will the AMA appeal these and other court decisions?

AMA will do whatever is necessary to ensure that physicians are not put in a position to kill and that patients die in comfort and dignity. If this means appealing directly or submitting amicus briefs or offering testimony, AMA will do so.

How does AMA feel about the $10 million defamation suit brought by Jack Kevorkian?

Even most proponents of physician-assisted suicide are appalled by Jack Kevorkian's activities. Abandoning bodies in parking lots falls well short of our societal expectations for death with dignity. AMA will continue to take a strong public stand on this issue. However, AMA will continue discussions with those whose opinions differ and will increase efforts to educate physicians in treating physical pain and the psychological needs of patients at the end of life. IM

"Nowhere in the Constitution does it state that individuals have a right to have their physicians kill them."

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How can you help overweight patients?

It's obvious—in small towns and in eities, at shopping eenters and the state fair—Iowans are getting fatter and their health is suffering beeause of it. According to a 1994 survey, 28.4% of Iowans are obese, up from 25.3% in 1989.

Obesity is assoeiated with the development of diabetes, hypertension and hyperlipoproteinemia, as well as inereased risk for developing cardiae and pulmonary diseases, stroke, some eaneers, gallbladder disease, pregnaney, fertility and surgery problems, gout, degenerative arthritis and early mortality. Psyehologieal problems related to poor self image and social problems ineluding diserimination in jobs, edueation and marriage are also complieations of obesity.

Physieian help is often sought for weight loss treatment and it is important for physieians to eneourage weight loss for anyone whose eurrent weight or weight gain pattern aggravates health problems or inereases risk for speeifie disease. If a patient is 10 pounds or more overweight, physieians should suggest a ehange in lifestyle and exereise.

Often, obese individuals will deny the impaet of their exeess weight unless their physician tells them it is a eoneern. Physieians ean use a weight/BMI (body mass index) chart to show healthy weight, moderate overweight and servere overweight ranges. (Call the Iowa Medieal Soeiety at 515/223-1401 or 800/747-3070 for a eopy .)

According to a 1994 survey, 28.4% of Iowans are obese, up from 25.3% in 1989.

Foeusing on health benefits, rather than appearanee, can help patients set realistie weight loss goals. A weight loss of as little as 10% ean result in signifieant improvement in blood pressure, blood cholesterol and blood sugar levels and ean reduee long-term eomplieations of diseases and need for medieations.

A eomplete physieial exam is important for anyone eontemplating a weight loss or exereise program to ensure no physieal problems exist that might be the eause of the obesity or that might eontraindieate diet or exereise treatment. Physieians ean then survey eating and exereise habits and eneourage ehanges in habits speeifieally through eounseling, written nutrition instruetions and a eontraet to lose weight.

Utimately, responsibility for weight management lies with the obese individual. Self monitoring—keeping food, weight and exereise reeords—has been found to be most useful. An individual ean develop strategies to control or avoid situations whieh prompt eating, sueh as stressful situations. Physieians ean provide follow-up for monitoring and support of weight loss efforts through normally seheduled offiee visits or more often as needed. IM

EDITOR'S NOTE: Numerous Iowa physicians are reportedly being asked about the new diet pill, dexfenfluramine. An Iowa physieian expert in weight loss will diseuss the pill in the September issue of *Iowa Medicine*.



KATHY RUEVE, RD

Ms. Rueve is a registered and licensed dietician with the Nutrition Center at Iowa Methodist Medical Center in Des Moines.

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Obesity in children and adolescents

● JENNIFER COOK, MD; RAYNA GROTHE, MD

Once obesity is established in adulthood it is extremely diffieult to treat. The sequelae of adult obesity include cardiovascular disease, diabetes mellitus, eertain forms of cancers and death.[1] Sinee being overweight as an adolescent increases the risk of being overweight as an adult, weight reduction in obese ehildren and adolescents may prevent adult obesity and its associated complications.[2]

The prevalence of obesity in children and adolescents is increasing. The Third National Health and Nutrition Examination Survey (NHANES III) from 1989-91 found 21% of people 12-19 years of age were overweight (males 20%, females 22%).[3] This is a 6% increase since the 1976-80 survey.

Identification

There are three methods commonly used in children and adolescents to assess obesity.[4] The body mass index (weight in kilograms/height in meters squared) requires having normative data for the child's age and sex.[5] Triceps or subscapular skinfolds estimate body fat.[6] This technique requires special equipment and skilled personnel. If not done meticulously, the variability in the measurements will be large.

Pereentage of ideal body weight (%IBW) is the method most eommonly used to assess obesity. It is the ehild's weight divided by the 50th%le weight for the age at which the child's height is in the 50th%le expressed as a percentage. This requires use of the National Center of Health Statistics (NCHS) growth chart which is part of every child's medical record. Obesity is classified as a weight equal to or greater than 120% of ideal body weight (IBW).

Thorough examination

The child with obesity needs a thorough evaluation to determine the etiology. A growth chart with heights and weight from birth to the present will provide the most valuable information. A child with exogenous obesity will have an accelerated weight velocity and linear growth greater than expected for their age. Hypothyroidism and Cushing syndrome will cause a deceleration in growth and increased weight. The child may have other symptoms suggestive of their disease such as lethargy. Children with Prader-Willi syndrome may have failure to thrive in the first two years of life and increasing weight gain after three years of age. Not all children with Prader-Willi syndrome are short.

A dietary history should be very thorough. A dietitian may be helpful in this assessment. A three-day food record may reveal that the child is eating more than anyone realized or has a high calorie and/or high fat eating pattern.

The patient's activity level should be addressed. It is important to obtain an estimate of exercise tolerance and sleep habits including snoring. Television viewing habits are informative. Increased TV time is associated with decreased activity and increased food consumption.[7-9]

If the review of symptoms is positive for headaches and blurred vision, this may suggest a hypothalamic tumor.

A family history of obesity, noninsulin dependent diabetes mellitus, hypertension and/or hyperlipidemia is important for determining the diagnosis and treatment.

On physical exam, an accurate height and

The IMS Education Fund has designated this article as the Henry Albert Presentation Award for July–August 1996.

JENNIFER COOK, MD
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Dr. Cook is a pediatric endocrinologist and Dr. Grother is a pediatric gastroenterologist at Blank Children's Hospital, Des Moines.

Obesity in children and adolescents

continued

weight will allow calculation of the %IBW. Blood pressure should be obtained with the correct size cuff. The neck should be checked for thyroid enlargement. The abdominal exam may be difficult due to the amount of adipose tissue. Tanner staging of genitalia is important since precocious puberty is more common with exogenous obesity and delayed puberty with most of the other etiologies of obesity.

A thorough neurologic exam will help determine if there is any central nervous system pathology. Striae on the skin are seen in all forms of obesity not just Cushing syndrome. Hyperpigmentation in the skin folds, acanthosis nigricans, is associated with hyperinsulinemia. Dysmorphic features such as small hands and feet may suggest a syndrome.

No routine tests for obesity

Most children do not require extensive diagnostic studies. There are no routine tests for all children with obesity. Each patient will need a specific set of studies. Diagnostic studies are based on the findings in the history and physical exam. If there are risk factors in the family history, cholesterol screening should be done. Bone age, thyroid function tests, 24-hour urinary free cortisol, karotype, calcium, phosphorous, and alkaline phosphatase should be considered when the child's linear growth is inadequate.

Children with delayed or advanced puberty need a bone age, serum gonadotropins and sex steroids. Hyperpigmentation suggestive of acanthosis nigricans is initially evaluated with a fasting serum glucose and insulin level. If there are features suggestive of Prader-Willi syndrome, a karotype is indicated. An MRI of the head should be done when there are signs of CNS dysfunction. Electrocardiogram, pulmonary function tests and sleep studies are indicated if there are symptoms or signs suggestive of decreased cardiac or respiratory function.

In the differential diagnosis of obesity, the most common etiology is exogenous obesity.[10] Exogenous obesity may have a genetic basis in some cases. This is a current area of research. In all cases, environmental factors such as dietary habits, activity and television viewing need to be addressed. Most of the other syndromes associated with obesity will usually be diagnosed after the initial evaluation. These include hypothyroidism, Cushing syndrome, growth hormone deficiency, Turner's syndrome, pseudohypoparathyroidism, Prader-Willi syndrome and hypothalamic tumors.

Complications of obesity

There are long-term complications to obesity. Twenty five to 50% of obese children and adolescents become obese adults.[10,11] Age of onset and severity are the two most important determinants of persistence of obesity into adulthood.[2] Children who remain obese as adolescents are more likely to remain obese as adults.[11] Obese adults with onset in childhood weigh more than obese adults with onset in adulthood.

Complications of obesity that occur in both children and adults (although less frequently in children) include hypertension, hypercholesterolemia, hypertriglyeridemia, hyperinsulinemia and insulin resistance, gallbladder disease, pseudotumor cerebri, Pickwickian syndrome and pulmonary function abnormalities. Complications that occur in children are early onset of puberty and slipped capital femoral epiphyses.[10]

The most severe sequelae of obesity in children and adolescents are psychosocial.[10] From age six years children have a negative stereotype of obese people. Overweight adolescents may have negative body images. Obese adult females who were obese adolescents completed fewer years of school, were less likely to be married and had lower household incomes compared to adult females who were not overweight after controlling for socioeconomic status and aptitude.[12]

Editor's note

Pickwickian syndrome is obesity accompanied by somnolence and lethargy, hypoventilation, hypoxia and secondary polycythemia. Samuel Pickwick is a character in the Charles Dickens novel *Pickwick Papers*. In the novel, one of the characters—Joe—is described as a "fat and red-faced boy in a state of somnolence". The term Pickwickian syndrome was first used by CS Burwell in an article on the syndrome in 1956. The name was chosen because Dickens' description is the first of the syndrome found in literature.

Multidisciplinary family treatment

There have been numerous approaches to the treatment of obesity. Studies have shown that dietary or exercise therapy alone will not be successful. In children and adolescents the only therapy that has been shown to have long-term beneficial effect on weight loss is a multidisciplinary family approach.[13] This includes diet, exercise and behavior management training for the child and parent(s). After completion of the initial therapy, children should be monitored on a regular basis to ensure that height and weight velocities are appropriate for the patient's age.

Summary

The prevalence of obesity in children and adolescents is increasing. For those whose weight is greater than or equal to 120% IBW a thorough evaluation is needed to determine the etiology. The majority of children will have exogenous obesity and will not require extensive diagnostic testing. Complications of obesity occur in children and adolescents with psychosocial being one of the more severe. Treatment is necessary to prevent complications and the only treatment that has been shown to be successful is a multidisciplinary family approach with long-term follow-up. The once a day pill to treat obesity is far in the future.

References

References noted in this article are available from the authors or the editors of *Iowa Medicine*. IM

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AIR FORCE

1996 IMS House of Delegates Proceedings

The 1996 Annual Meeting of the Iowa Medical Society House of Delegates was held April 20-21 at the Embassy Suites Hotel, Des Moines. House sessions were chaired by Donald Kahle, MD, speaker and Tom Throckmorton, MD, vice speaker. The Annual Banquet was held April 20 and was emceed by Joseph Hall, MD, IMS president.

House of Delegates Policy Actions

Reports considered by the 1996 House of Delegates came from the Reference Committee on Medical Service, the Reference Committe on Legislation and the Reference Committee on Reports of Officers and Miscellaneous Business. Based on consideration of the reports, the IMS will take the following actions:

- Amend the IMS Bylaws to allow an Iowa medical specialty society represention in the IMS House if the specialty society has been in existence for at least 5 years with at least 60% of whose members are also members of the IMS, and within 3 years of admission, 75% of its members are members of the IMS.
- Increase 1997 IMS dues by $10.
- Appoint a task force comprised of representatives of large physician groups, small physician groups, IMS Judicial Council, IMS Board of Trustees, solo practitioners and representatives of medical students and residents. The charge of the task force would be to study discounted dues plans and the potential fiscal impact of these plans.
- Referred a resolution regarding long-term use of insulin. (Resolution asked the IMS to do all in its power to require that insulin be by prescription only.)
- Reschedule a meeting between the IMS Executive Council and the Insurance Commissioner since the last scheduled meeting in January was cancelled due to inclement weather.
- Consolidate and summarize information on state regulations governing managed care organizations and publish it in *Iowa Medicine* with names, addresses and phone numbers of appropriate contact people.
- Compile a directory of information about existing and emerging physician-directed organizations in Iowa.
- Reaffirm IMS policy which calls for the IMS and its delegates to the AMA, through legislative and regulatory efforts, work to modify laws that have resulted in the current regulatory burden on nursing home practice and remove the unnecessary federal and state involvement in patient care in these institutions.
- Adopt a policy that the frequency of nusing home visits be based on the medical needs of the resident rather than on mandated frequencies.
- Reaffirm the IMS policy in support of medical liability reforms.
- Continue to consider tort reform a legislative priority.
- Encourage physicians to work with their legislators on tort reforms.
- Referred recommendations contained in the supplemental report of the Telemedicine Licensure Task Force.
- Referred a recommendation that the IMS ask the BME to explore whether physicians who perform utilization review across state lines are practicing medicine and to ask other professional licensing boards to do the same for their practitioners.
- Develop recommendations for educating physicians on chronic pain management by working with the Iowa Osteopathic Medical Association, specialty societies and the BME.
- Continue to support traffic safety legislation such as graduated licensing.
- Support the law prohibiting discrimination by insurance companies denying health or life insurance coverage for victims of domestic abuse.
- Study revisions on the certificate of need process.
- Encourage Iowa to join the class action lawsuit against tobacco companies to recover Medicaid funds expended in treating tobacco-related illnesses.
- Referred Resolution No. 12 which involved making second hand smoke exposure of a child or fetus a reportable form of child abuse.
- Adopt the recommendations contained in the Physician Assistant/Nurse Practitioner Task Force report.
- Reaffirm that care of our patients is of paramount concern.
- Endorse the AMA policy contained in the Patient Protection Act concerning due process of patients and physicians.
- Endorse the AMA policy that all health plans that restrict a patient's choice of physicians or hospitals be required to offer an optional "point of service type" feature so that a patient may elect to self refer to physicians outside the plan.
- Endorse the AMA policy to investigate and develop the feasibility of other free market solutions to provide patient access.
- Oppose all impediments to quality care and intrusions into the physician-patient relationship including financial incentives for not providing referral services, needed care and gag rules and physician contracts with managed care plans.
- Continue to monitor the impact of loss ratios and medical standards upon patient care and appoint representatives to the Iowa Alliance for Continuing Access to Specialty Care.

Award Winners

At the Annual Banquet, John Anderson, MD, Boone, received the 1996 IMS Merit Award. Paul Ferguson, MD, Lake City, was given the Physician Community Service Award. The John F. Sanford Award was given to David Lyons, who headed up the Iowa Health Care Reform Council. Diane Marshall, administrator of Dr. Randall Maharry's office in Des Moines, received the Outstanding Office Administrator Award. Blue Cross Blue Shield of Iowa Foundation was the recipient of the Washington Freeman Peck Award.

April 20 Session

Registered for the April 20 session of the House were 129

physician delegates. Minutes of the 1995 House of Delegates were approved as published in the July, 1995 issue of *Iowa Medicine*. Out of town guests and new delegates were introduced. John Nelson, MD, member of the AMA Board of Trustees, discussed AMA restructuring and the recent change in AMA leadership. He also discussed issues which are the focus of AMA efforts, including managed care gag clauses. U.S. Representative Greg Ganske addressed the House regarding the budget battle in Congress and his efforts to correct the bias toward urban states in Medicare reimbursement. Two checks totaling over $21,600 were presented on behalf of the AMA-Education and Research Foundation to Robert Kelch, MD, dean, UI College of Medicine. Dr. Kelch discussed how the checks are used by the University and gave an update on the new curriculum and other activities.

Reports to the House

Handbook reports were approved and supplemental reports were presented from the Board of Trustees, Judicial Council, Telemedicine Task Force and the Physician Assistant/Nurse Practitioner Task Force. Informational reports were heard or received from the IMS Education Fund, IMS Services, MMIC and Iowa Foundation for Medical Care.

The physicians' memorial list was presented by Kathryn Ophiem, MD, chair of the IMS Judicial Council, with delegates observing a moment of silence in honor of deceased physicians.

During the oral report to the House regarding Board of Trustees activities, Harold Miller, MD, Board chair, announced that Eldon Huston, IMS executive vice president, plans to retire as of December 31, 1996. A one-page informational report from the Board was distributed to the House regarding the schedule the Board plans to follow in the search for a new executive vice president.

As part of the oral report to the House regarding Judicial Council activities, the House affirmed an Executive Council action designating Tina Preftakes as an honorary IMS member. This action was taken by the House unanimously and by acclamation.

Kevin Cunningham, MD reported on the 1996 Iowa Legislature and activities of the IMS Committee on Legislation. Delegates also heard a report on IMPAC activities. Thomas Payne, MD of the AMPAC Board of Directors discussed efforts at the federal level.

IMS Officers for 1996-97

The slate of candidates for IMS offices was submitted by the Nominating Committee. There were no further nominations from the floor. The following officers were elected:

President-elect	Harold Miller, MD Davenport
Vice president	Hunter Fuerste, MD, Dubuque
Trustee (3-year term)	Sterling Laaveg, MD, Mason City
Speaker	Donald Kahle, MD, Dubuque
Vice speaker	Tom Throckmorton, MD, Spencer
AMA delegates (2-year term)	Clarence Denser, MD, Des Moines Bruce Trimble, MD, Mason City Donald Young, MD, Iowa City
AMA alternate delegate (2-year term)	Thomas Graham, MD, Iowa Falls

Six incumbent district councilors, elected prior to Annual Meeting, were affirmed by the House of Delegates. Steven Jacobs, MD, Cedar Rapids, was elected as the new councilor in District 4.

Thirteen resolutions submitted by councilor districts were introduced and referred to reference committees.

Life Members

Life membership was accorded to 40 IMS physicians:

Hoyt Allen, MD, Fort Dodge; Meyer Barrash, MD, Dubuque; George Bedell, MD, Iowa City; Cyrus Beye, MD, Sioux City; John Broman, MD, Maquoketa; Roger Boulden, MD, Lenox; Thaddeus Bozek, MD, Iowa City; Robert Byrum, MD, Bettendorf; John Clancy, MD, Iowa City; William Franey, MD, Cedar Rapids; David Funk, MD, Iowa City; John Garred, Sr., MD, Whiting; John Gambill, MD, Des Moines; John Graves, MD, Dubuque; John Green, Jr., MD, Des Moines; Dwayne Howard, MD, N. Sioux City; John Hoyt, MD, Creston; Kenneth Keane, MD, Sioux City; John Kersten, MD, Fort Dodge; Robert Klein, MD, Muscatine; Oscar Lanich, MD, Waterloo; Montague Lawrence, MD, Cedar Rapids; Ernest Lerner, MD, Mount Pleasant; Robert McCool, MD, Clarion; F. Benjamin Merritt, MD, Dubuque; Philip Monnig, MD, Sioux City; Richard Moore, MD, Des Moines; Herbert Nelson, MD, Iowa City; Donal Petersen, MD, Burlington; Richard Peterson, MD, North Liberty; Harry Readinger, MD, New London; Charles Ross, MD, Des Moines; Wayne Severson, MD, Des Moines; William Shinkle, MD, Des Moines; John Sibley, MD, Ames; William Southwick, MD, Des Moines; Emil Stimac, MD, Davenport; Michael Vruno, MD, Clinton; Louis Winninger, MD, Waterloo; and Chester Woodburn, MD, Des Moines.

Emeritus membership was accorded to 48 IMS physicians.

April 21 Session

Registered for the April 21 session of the House were 125 delegates. Minutes of the April 20 session were read and approved. The House of Delegates acted on reports from three reference committees and the speaker acknowledged the efforts of the committees. Joseph Hall, MD, IMS president, gave his departing speech focusing on entitlement spending and the federation of organized medicine. The House was adjourned and William McMillan, MD of Ottumwa was installed as president for the coming year. His incoming speech addressed the issues of community responsibility, service and maintaining the trust of patients and colleagues.

Organizational meetings of the IMS Board of Trustees and Judicial Council occurred following Dr. McMillan's installation.

Obesity in children

Obesity in children is an increasing health problem in the United States. The number of overweight children and adolescents in the U.S. doubled in the last 10 years. The increased incidence among 6-7 year old children has risen from 5% to 11% according to researchers at the Centers for Disease Control and Prevention. This increase rose alarmingly during the late 1970s.

These studies consider causes other than endocrine and metabolic disturbances. Though obesity can become evident at any age, the first year of life, the 5-6-year-old age group and adolescence are notable in the appearance of obesity. Overweight children are more prone to be overweight adults; overweight adults are at an increased risk for diabetes, shortness of breath, heart disease, decreased mobility as well as severe psychological problems.

Psychological problems might be either cause or effect. Feeding problems in infancy arise when food is used as a pacifier. Obesity ensues, and as a child grows older the obesity causes concerns over appearance, inability to partieipate in athletic endeavors and ridicule from their peers. Adolescents, especially girls, often take drastic measures to decrease weight. Athletes often undergo overzealous dieting to "meet weight".

Why are there so many obese children? Poor examples from their parents? Too many sedentary activities, e.g., television, computer games combined with junk food? Fear of playing outside after school because of criminal activities in certain neighborhoods? There are no clear-cut individual factors at fault. Some plead genetics, but I plead that a child surrounded by obese adults cannot help but join in consumption of unwise diets.

What can we physicians do about this prevailing social as well as health dilemma? First, we must recognize the problem. Fat is not happiness and good health. We must give wise advise to mothers of infants that overfeeding to satiate fussiness and crying is not a good health practice. Older children must be weaned from sedentary activities and provided with facilities for increased physical activity. The physical activity may include exercise programs, or team activities which have the added dimension of fostering group spirit. Parents must enhance a child's self-esteem and set good examples. That education must require solid encouragement, for children (especially adolescents) resent dogmatic direction. Our task is to help our patients and their families to live better, eat better, feel better and become more healthy. That is what preventive medicine is all about. IM

Overfeeeding to satiate fussiness and crying is not a good health practice.



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Religion and sex

If you won't read these words, after a title like that, you're hopeless. I chose that title after reading two novels, each recommended by a friend who thought I'd be interested because in each case the main character was a physician. That's certainly not enough to make the tale engrossing or to redeem feeble writing. But these two books scored with me.

The first was *The Cunning Man* by Robertson Davies, a well-respected Canadian author who recently died at age 82, soon after this book appeared. The physician protagonist had a highly unusual attitude toward his patients and their problems, yet one that would hold appeal for many "humanistically inelined" physicians. His personal life was also much different from what I suspect most of us live, or approve of. (I won't elaborate or I'd spoil the story for you.) The religious and sexual behaviors of many principal characters proved highly important to what ultimately became a story of murder. The author's splendid imagination and writing provide lots of ideas and actions with which to disagree, but good literature ought to be that way.

The contrasting second novel, *The Physician of London* by Stephanie Cowell, was a historical novel, a form I seldom read. This protagonist was a fictional physician as well as an Anglican priest during the reign of Charles I of England. Those turbulent days led to the Puritan revolution and the reign of Oliver Cromwell. Many of the characters were historical persons, including a large supporting role for William Harvey, "discoverer" of the blood's circulation and physician to the King. The protagonist's concerns as a priest exceeded his activities as a physician, but the glimpses of illness and the modes of therapeutic impotence in those days will command the interest of any thoughtful physician. And yes, there's some sex mixed in this story, too—nothing explicit—but of importance to the plot.

I'm not trying to present a book review but to point to how these novels can expand the reader's insights into the roles of religion and sex in the lives of one's patients. I'm sure any active physician can benefit from an expanded recognition of the enormous importance of religion and sex, and how these topics influence our patients, their diseases, illnesses, comfort, responses. Religion and sex are not always so intertwined as in these novels. Yet I'm fascinated at how often they are, so to speak, bedfellows.

I'm fascinated at how often they are, so to speak, bedfellows.

Continuing education for physicians regarding comparative religion and comparative sex can happen in many ways. Films and video may be more graphic than literature, although rarely as subtle or profound. Any of these modes may instruct, and fortunately, are attended by a happily low risk of sexually transmitted disease. IM



Richard Caplan, MD

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Locum Tenens—Board eligible FP interested in locum tenens in rural Iowa to provide ER, clinics and inpatient care with or without OB for up to 2 weeks at a time. Contact Vadim Braslavsky, MD, 7800 England, Suite 101, Overland Park, Kansas 66204; 913/383-3285.

Fort Dodge, Iowa—A busy otolaryngology practice is seeking locum coverage for weekends and some vacation time. Housing, transportation and malpractice provided. Send CV to Cindy Fellers, 800/360-4442; 804 Kenyon Road, Suite N, Physicians Office Building, Fort Dodge, Iowa 50501.

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Regular classified advertising sells for $2.00 per line with a $30 minimum per insertion. For members of the Iowa Medical Society the rate is $20 per insertion. Display classified advertising sells for $25 per column inch, per month. Sizes range from 1 column by 2 inches to 1 column by 6 inches. A variety of type sizes, borders, reverses or screens can be included in the ad. Blind box numbers are available upon request at no additional charge. Copy deadline is the 1st of the month preceding publication. Send or fax copy to *Iowa Medicine*, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

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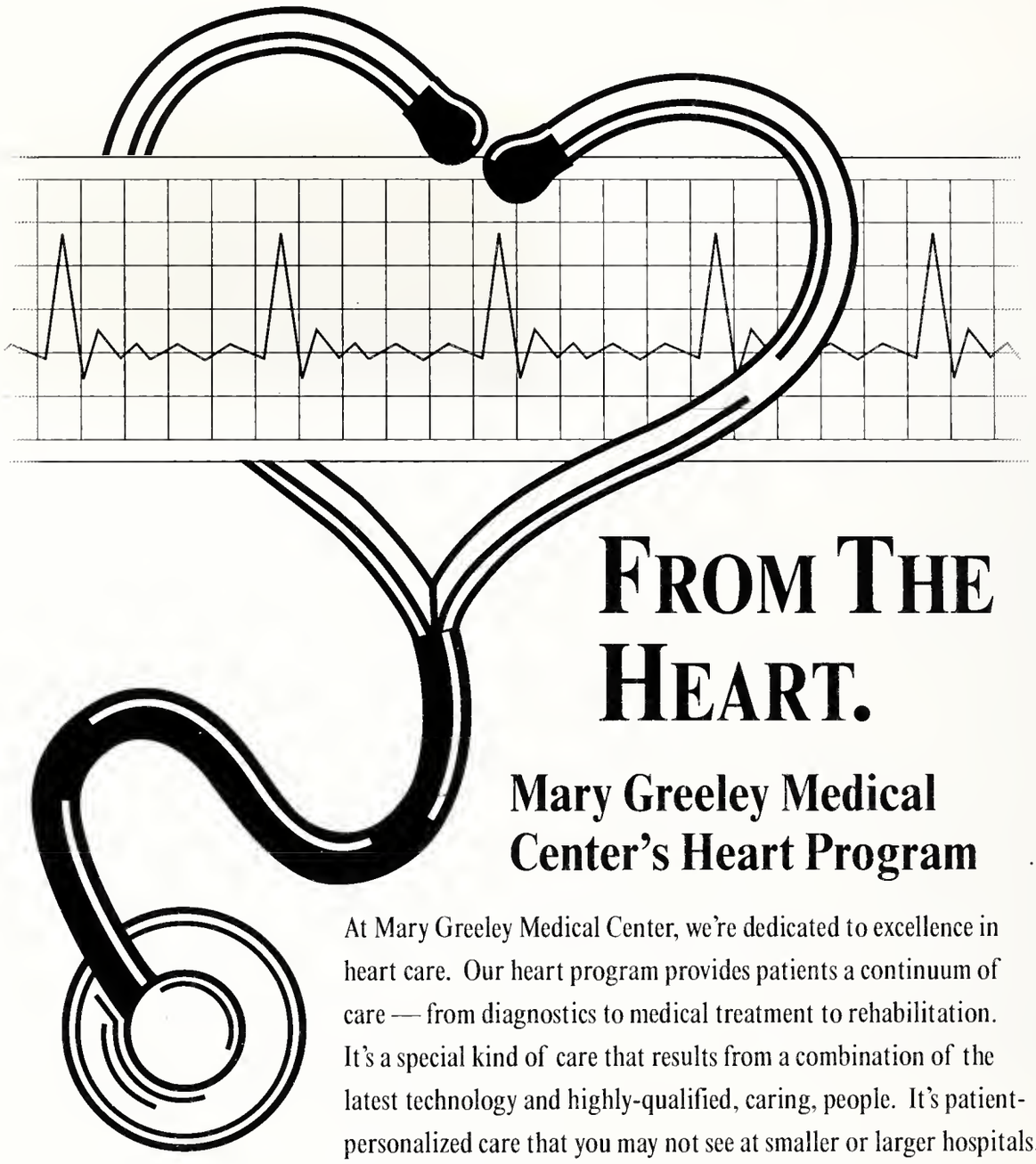
Dr. Gene Herbek (at left), IMPAC board member from Sioux City, with Dr. John Redwine, who is running for the state senate seat from Sioux City. Look on page 270 for a story about Dr. Redwine's campaign.

Mason City Clinic defies accepted wisdom
267

Iowa patients want anti-obesity drug
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Angioplasty treatment for peripheral vascular disease
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IMS *DEADLINE* news

SEPTEMBER, 1996

Late-breaking news of interest to Iowa physicians

●**POSSIBLE CHANGES IN THE IMS GOVERNANCE STRUCTURE** so the IMS can better represent the interests of physician groups will be on the agenda of a special task force scheduled to meet in late September. "To cope with the changes in the health care delivery system, Iowa physicians are uniting into larger and larger groups," comments IMS President Dr. William McMillan, who is in the process of appointing physicians to the task force. "The IMS, as the only organization representing the interests of Iowa's MDs and DOs, must be prepared to meet the needs of these groups in addition to serving solo and small group practitioners." Watch upcoming issues of *Iowa Medicine* for recommendations from the task force.

●**THE TASK FORCE ON THE IMS GOVERNANCE STRUCTURE** is just one of many recommendations contained in the Iowa Medical Society's 1996-97 strategic plan. The Board of Trustees held a strategic planning session in August and will finalize the plan this month. Other recommendations include a "making the rounds" program which will involve various IMS staff visiting county medical society meetings, hospital physician lounges and large clinics.

●**A DINNER MEETING WITH BME REPRESENTATIVES** is on the agenda for the IMS Board of Trustees for September. Issues to be discussed include an IMS House of Delegates resolution on chronic pain management and clarification of the administrative rule requiring a report when a physician has "firsthand knowledge" of acts or omissions of another physician.

●**THE SEARCH FOR A NEW IMS EXECUTIVE VICE PRESIDENT** to replace Eldon Huston — who is retiring — is progressing on schedule. As of press time, the Board of Trustees has narrowed the field to four candidates who will be interviewed this month.

●**A RESOLUTION REGARDING LONG-TERM USE OF INSULIN**, approved at the 1996 IMS House of Delegates, will be addressed by a work team of IMS staff and representatives of other organizations. Efforts will be directed at educating patients on the long-term use of insulin and the importance of regular follow-up with a physician.

●**THE AMERICAN MEDICAL ASSOCIATION** plans to convene a Coalition for Quality End-of-Life Care, a group the AMA says will be "dedicated to protecting patients at a time when they are vulnerable, fearful and in need of compassionate, competent care." The AMA has asked the IMS and other state medical societies to appoint physician representatives to the Coalition. The group's activities will include joint amicus curae briefs, press statements, outreach projects and a national symposium on end-of-life issues for health reporters.

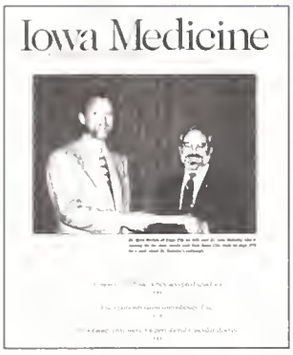
●**THE IOWA BME** has withdrawn rules relating to postoperative care because of lobbying of legislators by optometrists. The rules mirrored the AMA ethical guideline that the surgeon is responsible for postop care. The Iowa Academy of Ophthalmology and the IMS supported the rules. The IBME is working on another draft and has issued a declaratory ruling that postop care responsibility rests with the surgeon. Even without the rules physicians could be subject to sanction for failure to follow the guidelines.

●**THE IOWA DEPARTMENT OF INSPECTIONS AND APPEALS** has ruled that Iowa law does not require hospitals to include psychologists on the medical staff. The ruling responds to a petition by the Iowa Psychological Association asserting the contrary. The IMS and the Iowa Psychiatric Society appeared at a hearing and submitted written comments strongly objecting to the psychologists' interpretation.

For more information about any *DEADLINE* news item, call Chris McMahon at IMS headquarters, 515/223-1401 or 800/747-3070.

Iowa Medicine

SEPTEMBER 1996 / VOLUME 86 / 7



About the Cover

Dr. Gene Herbek (at left) is pictured with Dr. John Redwine. Dr. Redwine is seeking the state senate seat from Sioux City.

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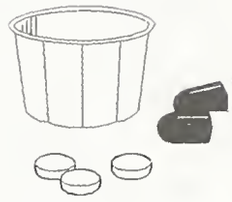
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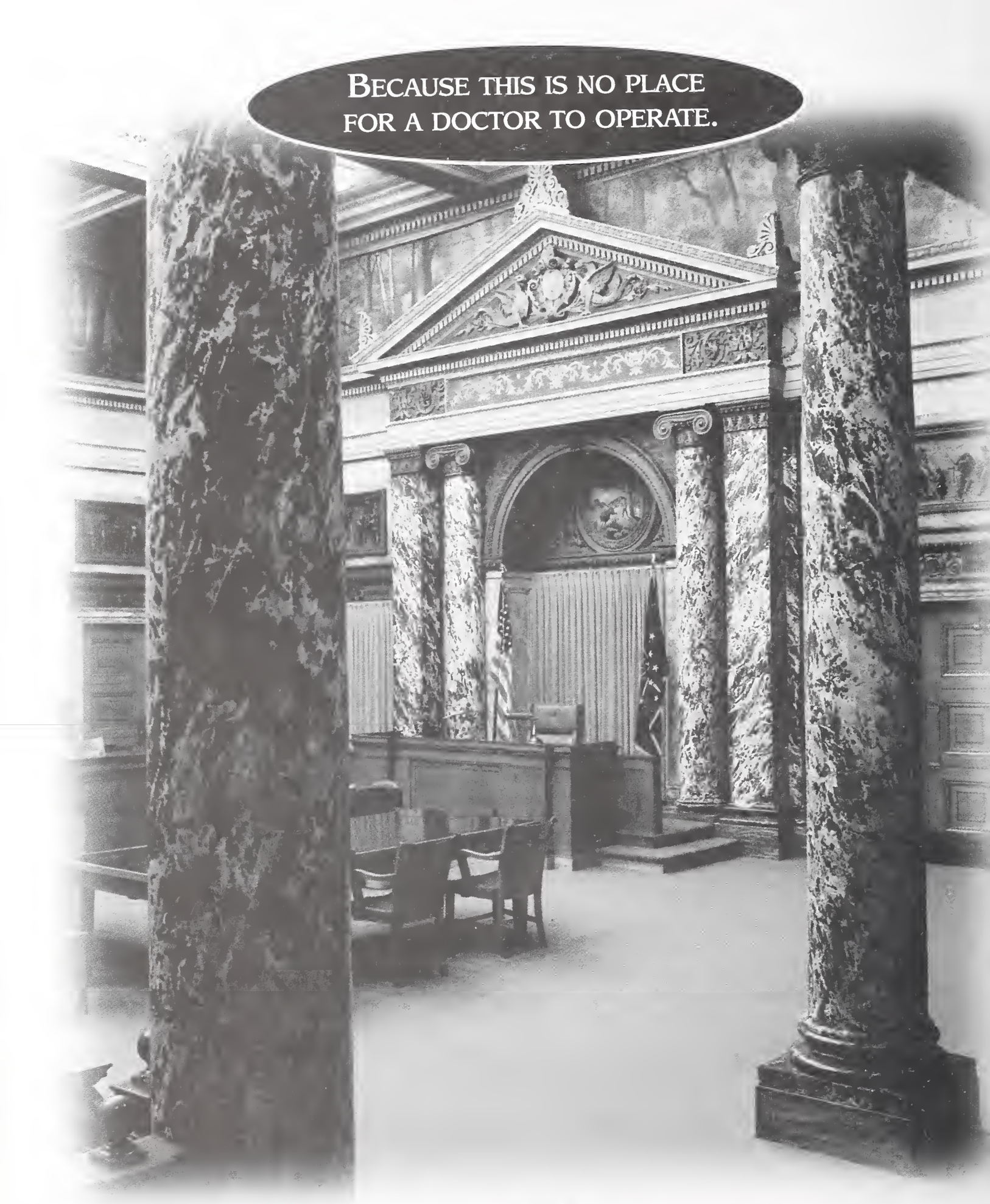
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'My patient was dying'

My patient was dying. We had struggled for three years against neck cancer and lost. His color was light blue. The 20+ cm mass that was slowly compressing his airway had stopped bleeding. Paul was not complaining. His pain medication provided a welcome relief to him and his family and to the hospital staff that occasionally suctioned the mueus that gathered in his throat. Three hours later Paul died. I told the staff not to wake me if it came after 1:00 a.m. or before 5:00 a.m., but I was in the house attending another patient so I could have talked to the family if they had been there. We had discussed Paul's death several times over the past few weeks. One visitor said he was going to stop smoking and another pledged to get help with his drinking. Maybe that would be Paul's last gift to us, but I don't know if they fulfilled those promises. I had distanced myself from Paul in his last weeks except for a couple calls from the family when they had used up their ability to cope with the advancing disease. In the hospital Paul was under my care and there were no bed sores and crying out in pain. He was always respectfully treated, clothed, shaved daily and had every opportunity for family visits. I think Paul would have wanted it that way.

In June, I met with six other physicians after a four-hour AMA Reference Committee meeting punctuated by passionate stories of patients who suffered painfully. Perhaps this made me more sensitive to the dynamics of the end of life. Certainly the testimonies given before that Reference Committee convinced me we have a lot to learn from each other about maintaining the comfort and dignity of patients we may want to put aside as "therapeutic failures". To paraphrase Osler, we are to cure when possible but to comfort always.

I admit I cannot fully understand the purpose of Paul's death. I do know our lives are an accumulation of our lifestyles and, perhaps, a healthy dose of luck without explanation. I also know we owe our patients like Paul all the dignity, understanding and comfort our community can give. Not so much as to measure Paul's worth as a human being, but as a measure of our humanity and compassion.

We have a lot to learn from each other about maintaining the comfort and dignity of patients.

The Iowa Medial Society has a committee for aging and chronic illness and is in the process of reviewing its charge to include a task force on chronic pain.

The AMA, as a result of the issues identified in the Reference Committee during its June annual meeting, has asked the Coucil on Medical Education to report on physcian education and end-of-life care for terminally ill patients. My reference committee said we must insure a caring and competent physician is there for all patients facing the end of life and who may be contemplating suicide. The Reference Committee, for reasons including the 2,500-year-old pledge

continued



WILLIAM MCMILLAN, MD

At the June AMA House of Delegates, Dr. McMillan served on the reference committee which considered the issue of physician-assisted suicide.

continued

to "give no deadly medication" and that 44 states have laws criminalizing physicians assisting in suicide, concluded we need to intensify our opposition to physician-assisted suicide and further expand the ability of physicians to relieve pain and restore controlled dignity and autonomy for dying patients. One month later the AMA called a meeting of health professionals who stated publicly their reasons for using physician-assisted suicide.

I believe that caring for patients and their families until and beyond death can be among the most rewarding aspects of medical care. Make no mistake, when it comes to caring for my patients' health and welfare I am their trusted ally. My patients can have faith I will continue to learn the best that medical science and the art of medicine have to offer for their lives from beginning to end. So should we all. IM

FOR MORE INFORMATION ON PHYSICIAN-ASSISTED SUICIDE

AMA efforts in the area of physician-assisted suicide didn't end with the June meeting of the House of Delegates. A packet of informational items was assembled in July and a Coalition for Quality of End-of-Life Care was appointed. The following materials are available by calling Bev Corron at the IMS, 800/747-3070 or 515/223-1401:

1. **Overall position statement on physician-assisted suicide (PAS);**
2. **A camera-ready Q & A with AMA Chair Dr. Nancy Dickey on the issue of PAS;**
3. **A generic speech on PAS;**
4. **A statement delivered by AMA Immediate Past President Dr. Lonnie Bristow to the U.S. House Subcommittee on the Constitution;**
5. **"Decisions Near the End of Life," a comprehensive overview of the myriad ethical issues involved at the end of life prepared by the AMA's Council on Ethical and Judicial Affairs;**
6. **Various editorials and/or articles.**

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MANAGED CARE

news you can use

Number of Americans in managed care plans grows rapidly

The number of Amerieans partieipating in some type of managed eare plan inereased 13% in 1995 to almost 150 million, aeeording to the Ameriean Assoeiation of Health Plans survey. PPO enrollment grew fastest at nearly 15% for a total of 91 million enrollees. HMO enrollment grew slightly less than 14%, to 58.2 million enrollees.

Sioux City organization joins Iowa Health System

After a year of diseussions, St. Luke's Health System in Sioux City has signed an agreement offieially affiliating itself with Iowa Health System. St. Luke's will remain responsible for its loeal operations, but the affiliation will allow it an opportunity to work with other physieians and hospitals. Integra Health is another affiliate of the Iowa Health System.

Nebraska joint venture delayed pending physician agreement

Aeeording to a July 29 artiele in *Modern Healthcare*, a joint venture between the University of Nebraska Medieal Center in Omaha and Alegent Health has been postponed while the aeademie medieal eenter settles differenees with its physieians and looks at other possible hospital partners. "The regents will take a serious look at the whole issue of affiliating with other hospitals or elinieal operations, so the university wants to put this on hold until the end of the year," said an offieial for the University of Nebraska system. The president of the University of Nebraska has eneouraged physieians to hold diseussions among themselves to deeide what they feel is important.

Increased legislative activity sparked by managed care

More than 400 laws relating to managed eare have been proposed in state legislatures this year, representing an unpreeedented level of aetivity, *Managed Care Outlook* reports. The industry is eoneerned over the number of the proposals, but some observers are optimistie beeause most new laws are less damaging than those of reeent years. Most of the laws proposed this year address maternity lengths of stay and gag elauses. A handful of states have passed sweeping patient proteetion laws, but most of the eomprehensive proposals have been defeated, leading to more foeused legislative efforts.

New version of the managed care contract gag clause

California's Sharp Healtheare is under fire after a eoneerned nurse leaked the eompany's handbook to several eonsumer groups. The handbook stated that "all employees have the responsibility to plaee the interests of Sharp Healtheare above their own and those of others."

Mason City Clinic defies accepted 'wisdom'

Editor's note: This article is based on a Q & A interview with Ralph Wolf, manager of the Mason City Clinic, in the March, 1996 edition of *Partners' Integration Advisor.* Excerpts are printed with permission of Partners Consulting Group, Ltd., Minneapolis.

The Mason City Clinic, a multispecialty group practice founded when three group practices merged in 1989, appears to defy the current collective wisdom that group practices must control primary care to succeed.

The clinic serves a 14-county area and represents 27 different specialists. The group has three family practice physicians and eight general internists, while common wisdom would dictate a primary care-to-specialist mix of 50:50 or more.

Recognizing true competition

"We believed our competition was not within our medical community but from surrounding tertiary care providers," explains Ralph Wolf, manager of the clinic. "We welcomed all the specialties within the community as opportunities presented themselves."

Prior to 1988, the Mason City Clinic didn't exist; today the clinic does $30 million in business annually. The guiding principle behind this success, says Mr. Wolf, is that physicians need to manage physicians. The clinic recently hired a full-time physician CEO who manages the clinic's 67 physicians and reports to the board of directors.

The initial step before creation of the Mason City Clinic was formation of a partnership which met market demands but stopped short of a full merger. Each physician contributed $1,500 toward development of a regional primary care strategy to compete with a local group practice.

"Prior to formation of the Mason City Clinic, the local political environment was tense, with more than 100 physicians, two hospitals and a 25-physician multispecialty group aligned with a smaller community hospital," relates Wolf.

"We were obsessed with the local competitive environment when the true threat was external. We realized that the goal should be market share. There is now one hospital system and the other competing multispecialty group has dissolved."

Support of hospital crucial

Wolf says that the initial merger would have been difficult — if not impossible — without the support of the local hospital, North Iowa Mercy Health Center.

"We (physicians) did not have the capital to develop a primary care network. The hospital did. Also, the hospital manages eight surrounding small rural hospitals, which provided an initial foothold in developing a regional primary care network," he relates. "To date, this interdependent strategy has proven to be effective in a limited market."

Wolf says the success of the Mason City Clinic has been driven by the following six factors:

1) Multiple mergers did not create a substantial drain on the clinic.

2) No one attempted to control primary care on a regional basis.

3) The strategy focused on regional market share and less on payment scheme prognostications such as capitation.

4) The group invested in a full-time physician manager who — even as a 'non-practicing' physician — retains the respect of colleagues.

5) Market forces eased the group into integration according to specified goals.

6) Market focus was directed outside the community.

"In some respects I suppose we've run counter to the prevailing wisdom, but we have not wavered from basic tenets of good business," Wolf concludes. "We've aggressively pursued our cost strategy, physician leadership and various collaborative strategies with the hospital. We continue to build on an infrastructure that will be responsive in a chaotic market." IM

We were obsessed with the local competitive environment when the true threat was external.

KEY CONTACTS:

Mason City Clinic
515/421-6501

Timothy Thomsen, MD
Chief executive officer

Ralph Wolf
General manager

If you know of other innovative practice arrangements — especially those controlled by physicians and positioned to compete in the managed care market — call Barb Cannon or Chris McMahon at the IMS, 515/223-1401 or 800/747-3070.

IMS Update

IMS Internet web site coming this year

The Iowa Medical Society's web site on the Internet is scheduled to be available to members late this fall.

The IMS web site will include deadline news updated daily, a calendar of events and the latest information on managed care, legislation and medical economics. There will also be a special section for news from specialty societies. IMS member physicians will also be able to send e-mail to IMS staff members through the IMS web site.

Check next month's *Iowa Medicine* for more information on this exciting new project.

IMS mentioned in *Medical Economics*

The Iowa Medical Society's Principles of Agreement for Managed Care was the subject of an article in the June 24 issue of *Medical Economics*. The article was entitled "Where plans and providers have come to terms".

Specialty society update

Dr. Philip Habak, president of the Iowa Chapter, American College of Cardiology will attend a legislative conference in Washington, D.C. in late September. Visits to the offices of Iowa's congressional delegation are planned.

The Iowa Psychiatric Society has decided to work with Iowa Managed Health Care Inc. and Dr. Tom Hansen to develop networks of psychiatric physicians to bid for managed care contracts. The IPS also plans to support activities of the Access to Specialty Care Coalition.

The Iowa Association of County Medical Examiners has been approved for a $5,000 grant from the Governor's Alliance on Substance Abuse. The grant will be used for speakers and panels on drug-related death. The group's next meeting will be September 27 at the IMS.

The Iowa Association of Pathologists will meet Friday, October 11 at the University of Iowa Memorial Union, in conjunction with the Iowa Anatomic Pathology meeting.

At a glance

Dr. Susan Blumenthal of the US Department of Health and Human Services will be a keynote speaker at Women's Health '96 Friday October 11 at the Drake Olmsted Center in Des Moines. For more information, call 515/288-4543.

Melanie Finke has joined the IMS staff in the position of communications specialist. She will be working with the IMS Internet project and specialty society newsletters.

The Iowa Substance Abuse Information Center has released a 10-minute video entitled "I'm Having a Baby". Filmed in Iowa, the video emphasizes the physiological and sociological impact parents have on their children before they are born. To order a FREE COPY, call ISAC at 800/247-0614.

News from Iowa Medical Group Management Association (IMGMA)

When I was asked to write this article on the importance of belonging to IMGMA, I could think of many reasons to belong and absolutely no reason not to belong. I have been a member since 1988 and have watched IMGMA grow into one of the best state organizations for medical management in the country.

IMGMA offers two meetings a year for managers to discuss concerns and problems, listen to nationally known speakers and attend workshops on a variety of medical management issues. IMGMA committees work hard to insure that Iowa managers have the tools to be among the best managers in the country. I go home from every meeting with a "pearl" which saved time and/or money. Whether it is coding issues, computer systems, new vendors for supplies and equipment, hammering out lucrative managed care contracts. . .there is always something innovative that has helped me with my practice management.

As a large state organization with a close affiliation to the Iowa Medical Society, many projects and programs are provided to benefit all of us. Without the latest information, it is impossible for physicians and managers to work together in making educated decisions about the future. I think everyone will agree the practice of medicine and medical management has changed dramatically in the last 20 years. Through organizations like IMGMA and IMS, we will insure that we thrive in the years ahead. If your manager is not currently a member of IMGMA, please contact Dana Petrowsky, executive director, for more information.

(This article was written by Lynn Fleckenstein, practice administrator for Siouxland Obstetrics & Gynecology, PC in Sioux City.)

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Office Communication Skills: Handling Difficult Situations Successfully★

September 24 — **Toy Bank Building, Lower Level Meeting Room, Sioux City, Iowa**

September 25 — **North Iowa Mercy Health Center, West Campus, Room 2, Mason City, Iowa**

This seminar is designed for all members of the office team and provides an intense, practical application of language skills, building people-to-people communication skills and improving your ability to prevent communication problems. The focus will be on handling difficult situations that occur in the medical office everyday as you interact with families, patients, vendors, physicians and co-workers.

Positively affecting the outcomes of challenging situations requires learning and applying specific skills. These skills will empower you to create respectful relationships whether face-to-face or on the phone.

Presenter: Kathryn Barrington, Business Resource Center, Eau Claire, Wisconsin. Kathyrn has a BA in education and has designed training and communication programs nationally and internationally.

Seminar time is 9:00 a.m. to 4:00 p.m.

The cost of the seminar is $99/participant which includes lunch. Registration after September 14 is $119.

★ This seminar is part of the IMS Medical Business Specialist (MBS) Certificate Program.

Registration Form

Office Communication Skills: Handling Difficult Situations Successfully

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Why every vote counts

Do one or two votes really count in an election? Consider:

•In 1994, a U.S. House incumbent from New York, opposed by organized medicine because of his legislative record, won election by a mere 55 votes. Imagine if one physician and Alliance member from each precinct in the district had voted for his opponent.

•In another 1994 race for the U.S. House, an incumbent opposed by organized medicine in Connecticut won by 21 votes. Again, imagine if one physician and one Alliance member from each precinct had cast their ballots.

With the passage of "motor-voter" legislation, registration is as easy as getting your driver's license.

If you know you will be out of town on November 5th or if your practice does not afford you the time to go to the polls, request an absentee ballot and vote early. IM

Focus on IMS Alliance

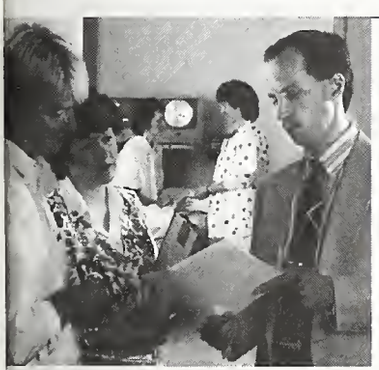
At the IMSA Summer Board meeting, I was pleased to deliver a sample "Baby Think It Over" transparency presentation. The presentation consists of 20 transparencies outlining teen and out of wedlock birth statistics and social concerns resulting from these births.

I encourage all IMS and Alliance members to request a "Baby Think It Over" transparency packet designed with your county statistics and use it to educate the citizens of your county about the facts, ramifications and the IMSA's solution to teen pregnancy—"Baby Think It Over".

"Baby Think It Over" is a comprehensive educational program that provides students with a realistic parenting experience which is changing teens' attitudes about parenting, the first step in changing their behavior.

Together, as physicians and physician spouses, we will make Iowa healthier and safer when we reach our goal of distributing 1000 packets. Let us make up one for your county today. Call Sandy Nichols at 800/747-3070 or Karen Messamer at 515/673-3751 for more information.

Together, as physicians and physician spouses, we will make Iowa healthier and safer.



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Legislative Affairs

Redwine's senate campaign in full swing in Sioux City

Physicians may have a different form of representation in the Iowa Legislature next session if John Redwine, DO wins his senate bid in Sioux City this November.

Dr. Redwine believes strongly that physicians must become involved in the legislative proeess. "Some issues are difficult to judge without a medieal baekground," Dr. Redwine comments. "With more health care decisions being returned to the state, physicians will become crucial to the legislative process."

A longtime IMS member, Dr. Redwine is quick to point out that his role in the Iowa Legislature is to represent the people of his district. He has an obvious interest in medical issues, but is also concerned about edueation, business taxes and state regulation of health care.

However, he plans to take stands opposing any willing provider legislation and in support of liability reform.

Dr. Redwine, a member of the Sioux City School Board, was approached to run after the ineumbent senator announced his retirement last winter.

"It's always a challenge to budget my time," says Dr. Redwine, who holds an administrative position at St. Luke's. "I expect to be working 14-16 hours a day during the session, but after struggling through medieal sehool and being in private practice, I'm used to it."

His campaign has gone smoothly. He ran uncontested in the primary; his opponent in the general election is Sandra Atkinson of Sioux City. Dr. Redwine says the candidate training he received from the AMA and the support of IMPAC and other organizations have made a big differenee.

Finally, Dr. Redwine stresses that being a legislator is a "vocation, not an oecupation".

"I'm looking forward to the opportunity to serve others and giving something back," he concludes.

Editor's note: Dr. Redwine is pictured on this month's cover with Gene Herbek, MD of Sioux City. The October Iowa Medicine *will look at Dr. Greg Ganske's campaign for reelection to the U.S. House of Representatives.*

AT A GLANCE

In a letter to William McMillan, MD, IMS president, Sen. Charles Grassley said he has received "considerable comment" from Iowans regarding fraud and abuse provisions in the Kennedy-Kassebaum health insurance reform legislation. Grassley also said the AMA is satisfied that a satisfactory compromise has been reached. However, the AMA continues to have concerns over the bill. Senator Grassley's letter was a reply to a letter of concern signed by Dr. McMillan and officials of the IH & HS.

Privately, Republican leaders fear that Bob Dole's lackluster campaign will lead to a landslide that could put Democrats back in control of the House and Senate, says the Kiplinger Newsletter. *President Clinton has locked up the key states of New York and California, with Michigan, Ohio and Illinois leaning heavily toward Clinton,* Kiplinger *says.*

CDC releases group B strep report

The much-discussed report from the Centers for Disease Control and Prevention relating to prevention of group B strep is now available in printed form. Family physicians, obstetricians, pediatricians and pathologists are strongly encouraged to review this report. (A summary appears on the next page.)

The IMS successfully opposed legislation during the 1996 session to put speeific requirements into Iowa law regarding prevention and treatment of this disease. The IMS believes medical decisions should be left to the physician, based on the needs of patients. The IMS encourages physeians to keep up with the latest research-based recommendations, whieh are included in the CDC report. The report was developed with cooperation of professional organizations including the American College of Obstetricians and Gyneecologists and the American Aeademy of Pediatrics.

Although the report is dated May 31, 1996, it was not released until the week of July 22. The full report, entitled **Prevention of Perinatal Group B Streptoeoceal Disease: A Public Health Perspeetive,** is contained in the *Supplement to Morbidity and Mortality Weekly Report*, May 31, 1996 / Vol. 45 / No. RR-7, or you may call Becky Roorda or Cheryl Peers at the IMS for a copy of the report.

Law on maternity care in effect July 1

The new law relating to health benefit coverage for maternity care went into effect July 1, but administrative rules to implement the new law are pending.

Several IMS physicians have been working with the Insurance Division on these rules. The final rules are expected to reference the Guidelines for Perinatal Care of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

The new law states that the length of hospital stay for both mother and baby is that determined to be medically appropriate by the attending physician(s) in consultation with the mother, using the AAP/ACOG guidelines. The law provides protection for physicians from adverse utilization review decisions if the physician follows those guidelines. The IMS asks physicians to keep track of problems and report them to IMS.

The new law applies only to insurance coverage and managed care plans regulated by the state and not to Medicaid or self-insured plans. The federal Employee Retire-ment Income Security Act (ERISA) preempts state regulation of self-insured plans, which comprise over half of health benefit coverage in Iowa. Many of the concerns about health benefit coverage reported by patients and physicians relate to ERISA plans.

For more information or a copy of the rules (when final) and guidelines, call Becky Roorda at IMS.

The Iowa Medical Society's Committee on Legislation will meet September 10 to begin formulating the IMS agenda for the 1997 session of the Iowa Legislature. If you have issues of concern, please contact Becky Roorda of the IMS staff, 515/223-1401 or 800/747-3070.

Centers for Disease Control statement on prevention of perinatal group B streptococcal disease (summary)

Group B streptococcus is a leading cause of serious neonatal infection. Most neonatal GBS infections can be prevented through the use of intrapartum antimicrobial prophylaxis in women who are at increased risk for transmitting the infection to their newborns. However, despite clinical trials that demonstrate the effectiveness of intrapartum antibiotic prophylaxis, prevention strategies have not been implemented widely or consistently and the incidence of neonatal GBS disease has not declined.

To promote a coordinated approach to prevention among obstetric and pediatric care practitioners and among supporting clinical microbiology laboratory personnel, CDC has developed prevention guidelines in conjunction with experts from relevant disciplines and with representatives of the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics and other professional organizations. This report provides the epidemiologic basis for prevention protocols, summarizes results of clinical trials demonstrating the efficacy of intrapartum antimicrobial agents, examines limitations of different approaches to prevention and presents guidelines for prevention of GBS disease.

CDC recommends use of one of two prevention strategies. In the first strategy, intrapartum antibiotic prophylaxis is offered to women identified as GBS carriers through prenatal screening cultures collected at 35-37 weeks' gestation and to women who develop premature onset of labor or rupture of membranes at <37 weeks' gestation. In the second strategy, intrapartum antibiotic prophylaxis is provided to women who develop one or more risk conditions at the time of labor or membrane rupture. Issues addressed by these prevention guidelines include the following: the appropriate clinical and laboratory methods required for prenatal screening programs designed to identify GBS carriers; risk conditions that indicate the need for intrapartum antibiotics; management of newborns whose mothers receive intrapartum antibiotic prophylaxis for GBS disease; and education of prenatal patients regarding GBS disease and available prevention policy.

These guidelines are intended for the following groups: a) providers of prenatal, obstetric and pediatric care; b) supporting microbiology laboratories, hospital administrators and managed care organizations; c) childbirth educators; d) public health authorities; 5) expectant parents; and f) advocacy groups for expectant parents. IM

CDC has developed prevention guidelines in conjunction with experts from relevant disciplines.

Medical Economics

AT A GLANCE

Ohio's attorney general has filed suit to stop the proposed sale of Blue Cross Blue Shield of Ohio to Columbia/HCA. The state alleges BCBS is a charitable organization and its assets must be preserved for public benefit.

A recent Wall Street Journal *editorial decried election year Medicare demagoguery, calling it "Mediscare". The editorial cited a t.v. ad in which Newt Gingrich is purportedly saying of Medicare: "We don't get rid of it in round one because we don't think it's politically smart." (Gingrich was actually talking about HCFA.) Such tactics are obscuring the true issues and making Americans ill-prepared to face the difficult long-term decisions that must eventually be made, said the* Journal.

Malpractice awards bouncing upward

According to a recent issue of *Medical Economics*, medical malpractice awards are on the upturn after falling to their lowest level in five years in 1994. The median jury award climbed 40% last year, according to the firm Jury Verdict Research.

Childbirth-related claims triggered the highest median verdict ($1.3 million); medication errors were next with a median award of $621,000.

DHS to change Medicaid intermediary

As of January 1, 1997, after 16 years with Unisys, the Iowa Department of Human Services will change its fiscal intermediary for the Medicaid program. Consultec, Inc. of Atlanta has been awarded the $50 million, three-year contract.

AMA supports CLIA reform bill

The American Medical Association is strongly supporting legislation which would exempt physician office labs from CLIA. Sponsored by Rep. Bill Archer in the House and Sen. Kay Bailey Hutchison in the Senate, the legislation has 125 bipartisan cosponsors in the House and nine in the Senate. Under the similar bills, pap smears would continue to be regulated under CLIA.

According to the AMA, "few other regulations have caused as much concern for physicians as those associated with CLIA."

HCFA criticized over Medicare booklet

A recent segment on NBC's national news broadcast was highly critical of the Health Care Financing Administration for spending $18.1 million to publish and mail a "glossy" informational booklet to 37 million Medicare recipients. Some households received two booklets. Reporters interviewed elderly people who questioned the expenditure "when we hear every day that Medicare is going broke."

HCFA spokesman Bruce Vladek told NBC that the booklet was intended to inform beneficiaries about "changes in the Medicare program" but admitted that the booklet mentioned nothing about those changes.

HCFA survey of practice costs

A HCFA survey of physicians' practice costs has been sent to an initial sample of 1,700 physicians nationwide. HCFA is required by law to use data on physicians' practice expenses to develop new resource-based practice expense relative values for Medicare's RBRVS physician payment schedule. The deadline is January 1, 1998.

At its recent meeting, the AMA House of Delegates called for a one-year delay in moving to the resource-based relative values to allow the national survey to be completed. Since information being gathered in this survey is not available from other sources, it is critical the survey be completed. Otherwise, AMA argues, HCFA will rely on proxies or some type of formula for physicians' actual practice expense.

The Practicing Physicians Advisory Committee — a key Medicare advisory body — has also suggested that it might be necessary to postpone the deadline until adequate data is available.

If these approaches fail, Congress may decide the matter. Changes in the practice expense portion of Medicare's physician payment system would be delayed for a year under a bill introduced in the House last month.

Eventually, the survey will be sent to 5,000 physicians. Any Iowa physicians receiving the survey are urged to complete it and return it as soon as possible. For more information, call Barb Cannon at the IMS, 515/223-1401 or 800/747-3070.

DATA & TECHNOLOGY

"Information is where the new age is. If you don't know your group's practice patterns, patient mix and costs of care in a capitated setting, you're fresh meat in the marketplace. Data gives you an understanding of doctors' productivity. It's the foundation for quality."

Eugene Ogrod, MD
California Medical Association past president

Health care is undergoing significant changes — from fee for service to managed care/capitation, from small group practices to large groups, from local decision makers to regional and national organizations. Accountability — defined as demonstrating value and quality — is the latest buzzword.

A recent poll of HMO, insurance and health executives reveals their priorities for capital spending:
77% — information technology
8% — buildings
12% — medical technology
14% — other

Providers, insurers, employers, health plans, managed care organizations (basically, everyone associated with health care) are being held accountable for appropriate and accessible services, cost efficiency, quality and consumer satisfaction.

To survive and thrive in this rapidly changing environment, physicians need a new set of tools. To prove efficiency and quality, physicians must analyze data which show how they practice medicine compared to their peers. To remain competitive, physicians must embrace new technology, i.e., using a computer system for patient billing, accounting and practice analysis; building an integrated network with strategic partners; implementing a computerized patient record (CPR) system; utilizing telemedicine to access a specialist in a distant location to consult on one of your patients.

In this day and age, keeping the status quo is a strategy for failure.

Beginning next month, this new page in *Iowa Medicine* will offer data and technology news you can use — practical information for today's medical practice.

What kind of information will you find?

•News on the latest quality and outcome measurement instruments from the National Committee on Quality Assurance, the Foundation for Accountability and others.

•Physician profiling projects conducted by the AMA, MGMA, payers, etc.

•Development of practice guidelines and clinical pathways.

•Survey results of what makes a satisfied patient.

•Criteria used by health plans to select participating providers.

•New applications for telemedicine.

We are in the information age. Ira Moscovice, director of the Institute for Health Services Research at the University of Minnesota, puts it this way: "The real technology issue is how to acquire information systems rural health professionals can use as we move toward a health care system that will be dominated by access to information." IM

What's important?

In a recent poll, the following factors were named by PHO officials as the most important in choosing physicians:

- **Board certification (37%)**
- **Clinical outcomes (21%)**
- **Utilization rates (16%)**
- **Specialty (16%)**
- **Patient satisfaction (10%)**

For more information, call Ed Whitver, IMS manager of health care data and technology, 515/223-1401 or 800/747-3070.

HEDIS 3.0 HAS A NEW FOCUS

The NCQA has released a draft of HEDIS version 3.0. The document is used to evaluate quality of care provided by health plans through participating providers. Earlier versions focused on preventive care such as the percent of infants immunized, percent of diabetics receiving regular foot and eye exams, percent of women receiving mammograms, etc. The newest version concentrates more on outcomes, looking aggressively at the data management of the acute and chronically ill. Version 3.0 is expected to be released in final form later this year.

Practice Management

Midwest Medical Insurance Company Focus on Risk Management

Failure to diagnose acute myocardial infarction

Diagnosing acute myocardial infarction (AMI) is one of the most difficult challenges a physician can face. A 1996 study of malpractice claims by the Physician Insurers Association of America indicates that the delay in diagnosis or treatment of AMI is a major source of malpractice loss for physicians.

The study revealed several significant factors regarding diagnosis of AMI:

- In over half of claims, the initial contact with the patient was in the physician's office.
- The most common presenting symptom was pain and/or pressure, cited by 93% of patients. The second most common presenting complaint was dyspnea.
- The most common initial impressions by the physician were gastrointestinal diagnosis in 26% of the cases and musculoskeletal pain (most often costal chondritis) in 21% of cases.
- An EKG was ordered in 59% of the cases, but over half were misinterpreted or the results were not received by the physician in a timely manner in order to make the diagnosis. No studies were ordered in 28% of cases regardless of the patient's complaints.
- In 55% of the cases, a failure or delay in ordering the appropriate studies was cited.

This study has shown that the diagnosis of AMI is often elusive and can easily be confused with other conditions. Maintaining a high level of suspicion with patients presenting with symptoms indicative of this condition, pursuing diagnostic testing and documenting thoroughly in the medical record can help improve patient care and minimize malpractice losses.

For more information contact Lori Atkinson, supervisor risk management, Midwest Medical Insurance Company, West Des Moines office, P.O. Box 65790, West Des Moines, Iowa 50265; 800/798-9870 or 515/223-1482.

AT A GLANCE

According to a recent issue of Kiplinger Newsletter, *the Internet will boom as the Main Street of computer communications, business dealings, contract negotiations, registrations and job searches. Internet will replace much of the software that is used in computers. These changes will take place within five to 10 years.*

Policy makers are debating whether to postpone changes in the practice-expense component of Medicare's physician payment system. Scheduled to begin in 1998, the changes would spawn pay hikes for primary care and cuts for surgery and other procedures. A delay in a survey of practice costs has prompted surgical and medical subspecialties to press for a one-year delay.

More MBS graduates

The Medical Business Specialist program has six new graduates.

Pictured in the photo at right are MBS graduates Nancy Evans (left), office manager at the Iowa City Heart Center, who was certified in March, 1996; and Mary Hildebrand, patient accounts manager at Mercy Services in Iowa City, who was also certified in March of 1996.

Linda Gibson, BSN, who was certified in April of 1996 is pictured in the photo on the next page.

Not pictured are new gradutes Patricia Retzl, RN, clinic manager for Genesis FirstMed Clinics in Davenport; Laura Schmitt, accounts receivable/payable, Family Health Center of Waverly and Mary Jane Zismer, neurology supervisor at Westside Orthopedics and Neurology in Dubuque.



Nancy Evans and Mary Hildebrand

There are also six new registrations in the MBS program, bringing the total number of



Linda Gibson

participants to 72. Fourteen people have been certified through the program; several more will certify with participation in upcoming fall seminars.

A calendar with recertification classes will be avavilable sometime this month. IM

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Newsmakers

AT A GLANCE

Dr. Ron Hawkins, family practitioner and medical director of the House of Mercy Free Clinic in Des Moines, was awarded the "Leading the Way Award" for making a difference in the health care field.

Acting surgeon general of the U.S., Dr. Audrey Manley, has appointed Sioux City surgeon Paul Johnson, MD as chairman of a committee to study ways to improve the use and effectiveness of the inactive reserve of the U.S. Health Service.

Dr. David Paulus, Red Oak, is one of 10 family physicians selected as a finalist for the 1997 AAFP Family Physician of the Year. Dr. Paulus was the 1995 Iowa Family Physician of the Year.

Letters to the Editor

Iowa Healthy Kids Project

Dear Editor:

This letter is a follow-up on the Iowa Healthy Kids Project. The Iowa Legislature, thanks to the assistance of Elaine Szymoniak, produced a bill to plan a pilot project for the provision of medical care to uninsured children of the working poor. The success was primarily due to the determination and efforts of David Carlyle, MD, while serving as president of the Iowa Academy of Family Physicians (IAFP); Steve Jacobson, president of Employment Benefit Services, Inc. and Jeanine Gazzo, lobbyist for the IAFP.

If your readers have questions, they can contact Steve Jacobson at 800/778-9878 or 515/223-9878. *—Don Green, MD, Des Moines*

Unexpert witnesses

Dear Editor:

A physician, having evaluated a clinical situation, interprets the data and makes a recommendation based upon his or her knowledge and experience. There is nothing especially unusual about this particular scenario, but let's analyze a slightly different wrinkle to the age old doctor-patient relationship.

Suppose that the physician makes a clinical judgement and in doing so makes an erroneous judgement. Let's assume the patient is harmed by this judgement. This is still a fairly common situation, one that we physicians are all aware occurs.

Now let's say that the clinical recommendation referred to a medication to be used for a cardiac arrhythmia and that the recommendation was made by a physician in family practice or neurosurgery who did not ordinarily make decisions about initiating treatment with such a medical regimen. If harm were to befall a patient involved in such a clinical scenario, one can envision the large number of adverse consequences that could befall the physician. Malpractice comes to mind and so does an investigation by the Board of Medical Examiners.

I believe this exact sequence of events happens frequently in medical malpractice claims when unqualified physicians testify against their colleagues. State law says when a physician testifies against another physician "the court shall only allow a person to qualify as an expert witness and to testify on the issue of appropriate standard of care if the person's medical and/or dental qualifications relate directly to the medical problem or problems at issue and the type of treatment administered in the case."

We know the popular idea that doctors won't testify against themselves is fallacious. In reality "hired guns" are easily available to testify for a price. Sometimes these physicians whose testimony is being authenticated by their medical license, make statements and suggest diagnostic and treatment regimens which are not indicated. In these cases when physicians are making erroneous testimony and that testimony comes from lack of experience, the adverse result (malpractice trial) is as egregious as a similar clinical situation involving care of an ill patient.

The judges handling malpractice cases have not enforced the expert witness law. We as physicians have no authority or ability to influence the judiciary's interpretation of this law. However, we do have some control over the licensure of the testifying physicians. The physician who gives erroneous testimony is doing so because of his medical license obtained from our State BME.

This situation seems to be identical to that created by the physician making the same type of medical decision and creating harm to a patient. Our BME has a right and a duty to examine erroneous testimony which produces and perpetuates a lawsuit and to sanc-

tion the physician guilty of that testimony.

I have requested our BME to examine three physicians who have testified against me erroneously and the investigation is ongoing. The BME is sympathetic to that process. I urge any physician who has been forced to endure a lawsuit which has been perpetuated by false testimony by unqualified physicians to request an investigation by our BME.—*Thomas Carlstrom, MD, Des Moines*

A personal tribute

Editor's note: This tribute briefly describes the life of Dr. John Moyers, Sr., 74, a well-known Iowa City anesthesiologist and IMS life member who died on April 22, 1996.

Jack was many things. He was president of the American Society of Anesthesia and chief of anesthesia at the UI College of Medicine. He was known and respected by the best in anesthesia across the land. He was an Iowan, a Hawkeye and he loved the University of Iowa.

Most of all, he was a teacher. Through those he taught, he will live on. He loved to teach. Thousands of medical students were greeted with his smile. He tried to bring common sense to the OR . . . "Watch the patient, not just the monitors. Never has there been a patient in serious trouble who had a warm, pink nose." And, "We have many staff from many places; listen and learn their tricks and techniques then do it your way with the best of each." He not only imparted knowledge, he tried to teach his students to think.

One only needed to watch Jack to define honor, devotion, ethics, duty, poise and common sense.

Jack, you taught us well. We'll dry our tears and carry on! You made the world a better place.—*Robert Eggers, MD, Clive*

Deceased members

John Martin, MD, 91, life member, neurological surgery, Iowa City, died May 29

Stanley Moen, MD, 85, life member, radiology, Cedar Rapids, died June 11

John Moyers, Sr., MD, 74, life member, anesthesiology, Iowa City, died April 22

Andrew Smith, MD, 75, family practice, Alamo, Texas, died May 10

Gary Smith, MD, 65, general surgery, Burlington, died June 1

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Medical Capital

Iowa patients want new anti-obesity drug

The media has been rife with stories about dexfenfluramine, the newest anti-obesity drug. The predictable result of this media coverage is that many patients are asking their physicians for the drug. In a special Q & A feature, a Des Moines family physician writes about the latest diet pill and a special ad hoc committee formed at his clinic.

What is dexfenfluramine and what does it do?

Dexfenfluramine, an anti-obesity drug, is a serotonin reuptake inhibitor and releasing agent. The aetion oeeurs primarily via deereased ealorie intake serotonergie meehanism or aetion in that it 1) inhibits serotonin reuptake by axon terminals; and 2) eauses release of serotonin from synaptosomes. This enhaneed serotonergie transmission seleetively suppresses appetite speeifieally for earbohydrates in a diet with a high earbohydrate to protein ratio.

Also, this drug apparently has no affeet on dopamine mediated neurotransmission in elinieal trails. Dexfenfluramine, when eombined with a redueed ealorie diet, is assoeiated with a deereased appetite and also may slow gastrie emptying. This should help patients attempting to lose weight who eat high earbohydrate meals and frequent high earbohydrate snaeks.

How does dexfenfluramine differ from other diet pills?

Dexfenfluramine is the first weight loss drug to be approved by the FDA in more than 20 years. It is the only drug to be approved for weight loss and for maintenanee of that weight loss when eombined with a redueed ealorie diet. Again, it has no dopamine mediated neurotransmitter effeets, unlike amphetamines and other serotonergie aetive agonist and antagonists.

What are possible side effeets?

The most eommon side effeets are drowsiness, diarrhea and dry mouth. These are usually mild and disappear in a few weeks. The most serious noted side effeet is the potential for primary pulmonary hypertension. The risk of this is estimated to be 18 eases out of every one million exposed patients per year. The oeeurrenee in the general population is one to two eases per one million persons.

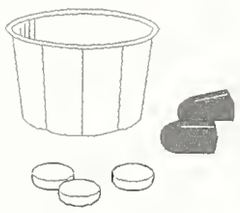
Obesity itself has been shown to inerease the risk about twofold. This is a rare but serious eondition with a four-year survival rate of approximately 55%. All patients should be advised to report inereased exercise intoleranee, ehest pain, syneope or lower extremity edema.

Very few patients will admit they want a pill to do all the work for them.

Are Iowa physieians being asked for this drug?

With the media eoverage of the phenteramine/pondaramine long-term studies in May of 1996 and

Wayne Belling, DO
Dr. Belling is a family physician practicing at Mercy West Medical Clinic in Des Moines.



the subsequent release of Redux (dexfenfluramine), Iowa physicians are busy screening numerous patients interested in these medicines.

Very few patients will admit they want a pill to do all the work for them. Most of them will report a very typical story of "eating very little and exercising all the time." Therefore, patient selection and patient education can be a real challenge. A number of family practice physicians I've spoken with are trying three to six well-selected patients initially to "test" the drug for their practices.

What issues should physicians be aware of when considering these requests?

There are a number of issues that a physician should consider in the use of this weight reduction/maintenance plan. First, all patients should have a current full history taken and complete physical. This should carefully screen for current and "prn" medicines including the "SSRI" antidepressants and MAO inhibitors. Patients should be specifically asked about their use of Imitrex since it seems so easy for patients to forget this if they only rarely require this medicine.

Careful screening for heart and lung disease, as well as thyroid function abnormalities is also essential. This medicine should be used with caution in patients with glaucoma. There are innumerable other issues, as well as that need to be considered on an individual basis. The physician must evaluate a patient's motivation to get the medicine and motivation to make lifestyle changes of significance. No medicine can be ultimately successful in weight management without personal lifestyle changes.

Is this drug effective for long-term weight loss?

The data so far looks good for the effectiveness of this medicine. The long-term data, however, is still somewhat weak due to the newness of the medicine. We have some one year results, but weight management is a lifetime concern and the physician's position on this medicine would strengthen with five and 10-year data.

This medicine does seem effective for the properly selected, properly motivated patient, at least for the first year. Unfortunately, just as nine out of 10 drivers think they are better than average drivers, so nine out of 10 obese patients insist they are the one patient who will be successful "if they can just get the diet pills". There also is data supporting giving successful "dieters" dexfenfluramine when they hit a plateau in their weight loss program.

A number of family physicians I've spoken with are trying three to six well-selected patients initially to "test" the drug for their practices.

Tell us about the committee formed at your clinic to address concerns and make recommendations about the diet pill.

Anticipating an onslaught of patients demanding these medicines, our clinic formed an ad hoc committee in May of 1996. We are a group of approximately 20 family practice physicians in a suburban setting. We knew we would be easy targets of this onslaught if we didn't organize ourselves. The purpose of our committee was to study and distribute the available information and to put together at least some minimal standards of patient evaluation necessary to properly prescribe these medicines.

We were careful in our efforts not to tell an individual physician how to practice. We sought to educate physicians and to set minimal standards of evaluation and follow-up so we could present a uniform front to our patients just as we would with other illnesses in our practice. IM

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The Journal
of the Iowa Medical Society

Angioplasty treatment for peripheral vascular disease

● *Liberato Iannone, MD; Randy Rough, MD; Magdi Ghali, MD; Koreen LeMaster Rayl, RN; Steven Phillips, MD*

The literature of peripheral vascular angioplasty suggests that patency rates are superior in stenoses or occlusions of less than 10 cm.[1-4]

Krapel found that angioplasty of lesions less than 3 cm long in femoro-popliteal vessels achieves excellent results.[7] Martin reported a 63% patency in patients with occlusions of 4 cm or less compared to a 44% patency with occlusions of greater than 5 cm.[8] Zeitter reported poorer outcomes with angioplasty of superficial femoral artery occlusions greater than 12 cm in length compared to occlusions of less than 12 cm.[13] Chien-Tai Lu, *et al*, conclude that angioplasty is appropriate for patients who have 10 cm occlusive disease (with popliteal involvement) for whom vascular surgery is not feasible.[2]

The literature describes a higher success rate with iliac arteries as compared to femoral-popliteal segments. Rooke reported that angioplasty above the femoral bifurcation achieved better results (86%) than angioplasty below the bifurcation (53%).[11] Johnston found that the success rate of common iliac artery angioplasty was higher than other sites and superior to the external iliac artery.[5]

This report compares our experience to the literature with peripheral vascular angioplasty of lesions 1-48 cm in 68 patients.

Sixty-eight patients, 76 procedures

From 1987–1989, 68 patients (51 males, 17 females) underwent peripheral transluminal angioplasty (PTA) for arterial lesions from 1 to 48 cm (mean 11 cm) in length in the iliac and lower extremity vessels.

The mean patient age was 63 years (26 to 85 years). Multiple risk factors and diffuse atherosclerosis were common. Twenty-four patients (30%) had diabetes, 36 (45%) had hypertension and 50 (64%) had a history of nicotine abuse. Fifty-eight (85%) patients had known coronary artery disease with 24 (35%) having previous coronary artery bypass surgery, 14 (21%) had previous peripheral vascular surgery and 7 (10%) had both peripheral and coronary surgery (Table 1).

These 68 patients had a total of 76 procedures involving 116 arteries. Each extremity was regarded as one procedure. Twelve angioplasties were assisted by laser, 15 by thrombolytic therapy and 2 utilized both. The length of the lesions varied from 1 to 48 cm, with a mean of 13 cm. Early and late clinical outcomes were evaluated up to 36 months (mean 11 months). Variables such as length of lesion, artery, lesion site and associated conditions were statistically analyzed. PTA in the 68 patients was performed in 16 (19%) for limb salvage and 60 (81%) for claudication.

Early success (less than 30 days) was defined as an immediate angiographic decrease in the percentage of the lesion or occlusion by 50% associated with complete or partial relief of symptoms. Failure was defined as less than a 50% angiographic improvement with no change or worsening of symptoms. Late success (greater than 30 days) was defined by patients being symptom free or improved with an increase of the ankle arm index (AAI) by 0.10 as compared to preangioplasty.

Influences on success rate

Seventy-sex procedures were performed in 68 patients with a technical success rate of 72.4% (55/76). Success was 71.1% by lesion and 75.9% by artery. Technical failure was

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for September 1996.

Liberato Iannone, MD
Randy Rough, MD
Magdi Ghali, MD
Koreen LeMaster Rayl, RN
Steven Phillips, MD
The authors are associated with Iowa Heart Center/Mercy Hospital in Des Moines.

Angioplasty treatment for peripheral vascular disease

continued

TABLE 1
VARIABLES OF HIGHER LONG-TERM SUCCESS RATE

Variable	*Success rate w.*	*Success rate w.o*	*p value*
*Trifurcation disease	4/8 (50.0%)	34/42 (81.0%)	0.06
Previous surgery	6/9 (66.7%)	32/41 (78.0%)	0.5
PVD	11/16 (68.8%)	27/34 (79.4%)	0.4
Known CAD	28/38 (73.7%)	10/12 (83.3%)	0.5
Diabetes	9/13 (69.2%)	29/37 (78.4%)	0.5
*Hypertension	14/22 (63.6%)	24/28 (85.7%)	0.07
Nicotine abuse	26/36 (72.2%)	12/14 (85.7%)	0.3
High cholesterol	14/17 (82.4%)	24/33 (72.7%)	0.5

**Trifurcation disease and hypertension are the only variables predictive of higher long-term success rate.*

TABLE 2
LENGTH OF LESION AND TECHNICAL SUCCESS RATE (P>0.5)

Length	*# of patients*	*% successful*	*# of patients*	*% failed*
1–5 cm	19/26	(73.1%)	7/26	(26.9%)
5–30 cm	29/44	(65.9%)	16/44	(34.1%)
> 30 cm	7/8	(87.5%)	1/8	(12.5%)

30.8% by procedure, 28.9% by lesion and 24.1% by artery. The absence of trifurcations disease (p>0.06) or hypertension (p>0.07) was associated with a statistically improved long-term success rate. There was no statistical evidence to support that the absence of any of the other investigated variables influenced the rate of success or failure (Table 1).

Follow-up at a mean of 11 months (1-36 months) was done in 50 of the 55 sueeessful procedures. Success was 38 of 50 (75.8%) for procedures with 75.9% for lesions and 75.7% for vessels. For lesions that exceed 10 cm 65% were improved at follow up (Table 2). The AAI, measured from 3-24 months in 28 patients, improved in 23 (+0.9) (Table 3). Six of 10 patients with improved AAIs were considered late failures because of reeurrent symptoms.

The site and length of 54 treated lesions in the common iliac, external iliac, superficial femoral, popliteal, anterior tibial and perineal arteries were compared. There was no significant difference in the suecess rates among these vessels (Table 4). In the limb salvage group 69% (11/16) were technically successful. Technical suecess for the claudicant group was 73% (44/60).

Complications

Complications included two amputations, one dissection, three perforations (two required surgery) and one death. Both amputee patients had severe peripheral vaseular disease involving the trifurcating vessels. One patient with an acute myocardial infarction had surgically inoperable peripheral vascular disease. Because of ischemic rest pain, a salvage angioplasty of the anterior tibial artery was attempted. A 13 em lesion was initially opened but closed post angioplasty nessitating a below the knee amputation.

The other amputation was in a patient with known single vessel runoff below the knee. Following sueeessful coronary angioplasty, this patient developed a femoral thrombosis at the eatherization site. Emergency lytic therapy with angioplasty failed resulting in an above the knee amputation 18 days later. Surgery was required to repair a femoral arterial perforation during angioplasty of a 15 em oeclusion. Another emergency operation was done after laser assisted angioplasty failed to open a superfieial femoral artery and resulted in a dissection. One perforation during an attempted opening of a 2.5 em superficial femoral oeclusion was managed without surgery.

One reported death

The single death occurred in a diabetic female who developed an ischemic leg following coronary artery revaseularization surgery. Angioplasty to open an occluded iliac artery failed; the patient expired one day after emergency surgery. Two additional complications included one distal embolus and one gastrointestinal hemorrhage. Neither patients had significant sequale.

The clinical course of patients considered technical failures was evaluated. Elective peripheral bypass surgery (6-365 days post PTA) was performed on 6 of 10 patients with recurrent symptoms. Four patients were not surgical candidates and were followed medically. One died approximately 45 days post angioplasty attempt. This patient was a brittle diabetic with dialysis dependent end stage renal disease.

TABLE 3
ANKLE ARM INDEX*

Improvement	*Number of procedures*
-.10 to -.01	3 failures
.00 to .09	7
.10 to .19	3
.20 to .29	3
.30 to .39	4
.40 to .49	5
.50 to .59	1
.60 to .69	2

**Changes in the Ankle Arm Index pre and post PTA measured in 28 patients between 3 and 28 months post PTA.*

TABLE 4
RESULTS BY VESSEL (P>0.7)

Vessel	*Success rate*	*Failure rate*
SFA	28/36 (77.8%)	8/36 (22.2%)
POP	11/14 (78.6%)	3/14 (21.4%)
I	8/13 (61.5%)	5/13 (38.5%)
AT&PER	4/6 (66.7%)	2/6 (33.3%)

SFA—superfiecial femoral artery
POP—popliteal
I—iliac
AT&PER—anterior tibial and peroneal

Data analysis

The literature indicates that long-term patency rates after PTA are influenced by symptoms.[1-4] Patients who experience intermittent claudication have better results from angioplasty than those who are classified as limb salvage. This was not true for our patients who had a 69% success rate with limb salvage PTA and a 73% success rate for claudication PTA. Lesions 10 cm or greater, according to the literature, demonstrate inferior results after PTA.[1-4,7,8,12] Analysis of our data revealed no statistical difference (p>0.2) in success rates with PTA in lesions of less or greater than 10 cm (Table 2).

Single site dilatation appears to have a better end result when compared to dilatation at multiple sites, but was not confirmed by our results (Table 4).[5,11] The literature indieates that patients with diabetes and nicotine abuse have poorer results with PTA [10] but this also was not born out in our study (Table 1).

Patients with symptomatic peripheral vascular disease can be managed with angioplasty as an option to bypass surgery or in conjunction with bypass surgery. It is generally felt that lesions longer than 10 cm are technically more difficult PTA and may have a higher complication rate.

Our study indicates that PTA can be performed safely to peripheral vascular occlusions from 1-48 cm in length with a favorable long-term result. Variables such as comorbid vascular conditions, trifurcation disease and hypertension may influence complications and long-term results.

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Gambling is addictive

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Recent reports of the extent of addiction to gambling in Iowa are appalling to say the least. Over a 10-month period since July 1995, calls to a state-supported hot line for problem gamblers increased by 248% over the same 10-month period a year earlier.

In April of this year the state began an advertising campaign to urge problem gamblers to confront their problems. Isn't it ironic that the state sanctions gambling only to have to sponsor help for problem gamblers? Polk County proudly reports in the press the millions of dollars that derive from one casino/race track alone. These glowing reports, however, are often tainted by disagreement on how to spend the windfall. Iowa law decrees that gambler treatment programs be financed by a tax of 0.3% upon sales of the Iowa lottery and the gross gambling revenue of Iowa riverboats and race track casinos. Casinos sponsored by American Indian tribes are exempt, even the reporting of their revenues.

During fiscal year ending June 30, 1996 it is estimated between $1.2 and $1.4 million will be spent on advertising and education and $1.2 million on treatment efforts.

Devastation upon some families in Iowa has become a social blight. There have been broken families, financial problems and an increase in criminal activities. The National Council on Problem Gambling has found that 75% of gamblers treated in in-patient centers have committed a crime. Between 1988 and 1994 Minnesota counties with casinos experienced a crime rate rise twice as fast as those without casinos. Fraud, theft and forgery/counterfeiting are typical crimes associated with gambling.

Chronic gamblers pay the price of gambling through credit card delinquency and bankruptcy. Welfare payments are too often used at casinos. Families, especially children, suffer consequences as well. Though many gamble at casinos for entertainment (estimated at 95%), the 5% who are addicted are those with all the problems such as lying and cheating, not to mention the increased rate of attempted suicide.

Since July 1995, calls to a state-supported hot line increased by 248% over 1994.

The citizens of Iowa have to face reality. Gambling is a real problem. Compulsive gamblers bear an addiction worse than drugs, yet government officials are like complusive gamblers . . . wanting to create more revenue. They too are afflicted with "the disease of barbarians superficially civilized". When 48 of the United States have legalized gambling and almost 100 million Americans bet $400 billion last year and lost $39 billion to the "house" it is truly a serious problem. IM



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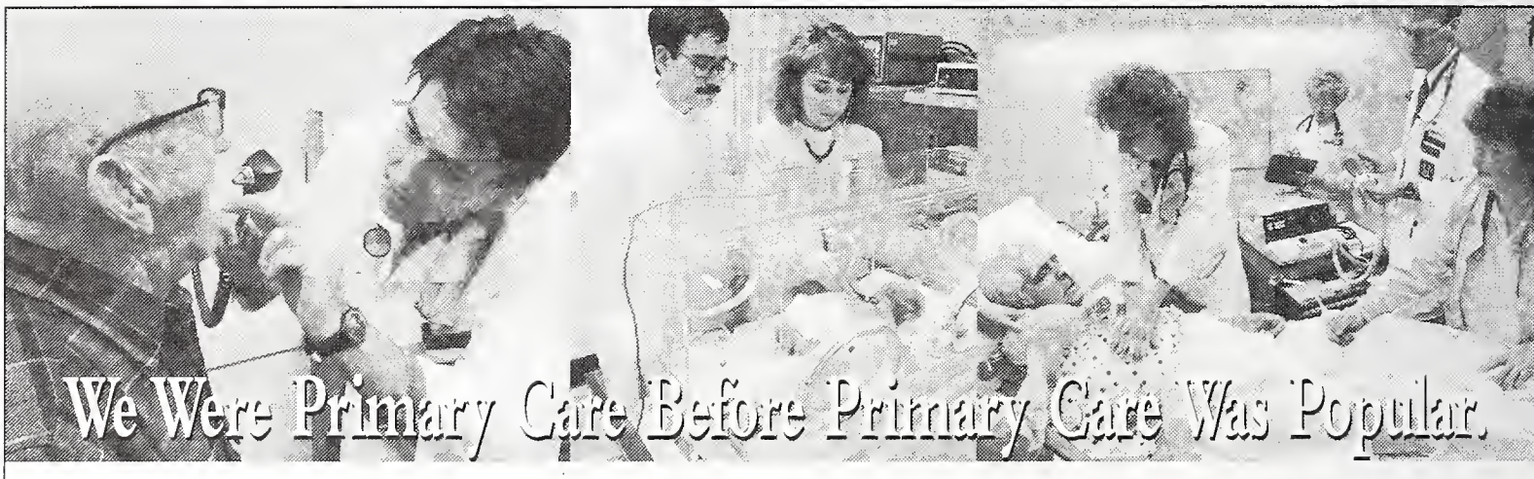
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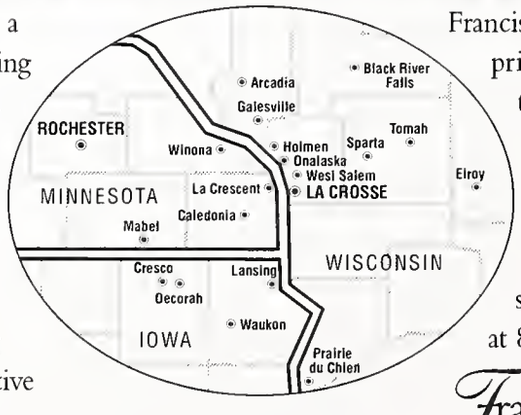
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Achieving clinical confidence

There is widespread discussion about how to improve the quality of medical practice through continuing medical education. Studies confirm that passive learning (e.g., listening to lectures) minimally alters physician practice behavior. Practice behavior evolves as physicians learn about new medical management approaches and develop the confidence to use them in their day-to-day work with patients. That confidence is often bolstered by the reinforcement and support of physician colleagues.

Just how can structured continuing medical education convey both knowledge and confidence? The physician must be an active participant in the process. Many CME conferences now utilize the working format in which a moderator or facilitator guides participants through materials, which may include case studies or other problem-solving exercises. The participant must think about the issues and come to conclusions independently. This approach often intimidates physicians, whose practice mindset is to achieve 'zero tolerance' for error. Incorporating new knowledge, and thereby altering management, threatens stability. Confidence is undermined.

Educators are devising new methods to provide feedback to physicians during the learning process. A simple and direct approach is to offer self-administered quizzes after the presentation of material. The results of these quizzes, aggregated anonymously, can also provide direction to the instructor in reinforcing or reviewing material. While these methods can use pencil and paper and simple tallies, there are now software programs that can accomplish the same summations instantaneously. These programs rely upon the wiring of learning stations to the instructor's teaching station, providing an instantaneous result and cue to the instructor to present material in a somewhat different way or review the issue again.

Perhaps the broader cultural change required to instill confidence must be found in the practice environment. In the daily care of patients it should be acceptable and desirable for physicians to ask questions of one another and to seek information and feedback from other health professionals when a team is involved in the care of patients. An open and questioning environment encourages dialogue, avoids decision-making that is based on inadequate information and fosters a sense of inquiry. The practice of medicine requires almost continuous adaptation and flexibility to assure appropriate diagnosis and treatment. Being confident practitioners should imply an openness to challenge and a willingness to apply new knowledge in the care of patients. IM

The practice of medicine requires almost continuous adaptation and flexibility.



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(Continued next page)

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Iowa Medicine

JOURNAL OF THE IOWA MEDICAL SOCIETY | OCTOBER 1996

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IMS *DEADLINE* news

OCTOBER, 1996

Late-breaking news of interest to Iowa physicians

●**CONGRESS HAS JUST PASSED LEGISLATION** setting minimum requirements for payment of hospital care after delivery of a baby. Meanwhile, administrative rules implementing Iowa's maternity care law have been published for comment by the Iowa Insurance Division. The federal legislation will not supersede Iowa's law which provides that the decision on length of hospital stay is left to the medical judgment of the physician in consultation with the patient.

●**THE IMS HAS E & M CODE** utilization data for July - December, 1995 for Medicare patients in Iowa and the nation. For a copy, send a stamped, self-addressed envelope and the specialties you want to: Barbara Cannon, Iowa Medical Society, 1001 Grand Avenue, West Des Moines, IA 50265.

●**THE IMS BOARD OF TRUSTEES MET WITH REPRESENTATIVES OF THE** Board of Medical Examiners in September to discuss a number of issues. Items of discussion included the BME's new Impaired Physician Review Committee, chronic pain management, reporting of impaired colleagues to the BME and the BME's investigative methods. Ann Martino, executive director of the BME, told the IMS Board that due to fear of being excluded from managed care panels, physicians are much less willing to settle charges without full legal recourse.

●**THE IMS BOARD OF TRUSTEES IS PROGRESSING ON SCHEDULE** with the search to replace IMS Executive Vice President Eldon Huston, who is retiring. The Board completed interviews with three candidates on September 18. As of press time, the Board had chosen a candidate but negotiations with the candidate were incomplete. All IMS members will receive news of the search outcome as soon as it can be announced.

●**THE IMS TASK FORCE ON GOVERNANCE** will hold its first meeting October 10. This task force, chaired by Donald Kahle, MD, speaker of the IMS House of Delegates, will study the effectiveness of the entire IMS governance structure. The task force is charged with finding ways to better represent IMS members in the new health care environment. If you have questions about this task force or ideas for the members to consider, call Dean Gillaspey at the IMS (800/747-3070 or 515/223-1401).

●**IOWA IS ONE OF SEVERAL MIDWEST STATES** which has formalized its participation in the Geographic Coalition for Fair Medicare Reimbursement. For several years, the Coalition has attempted to work through the AMA but due to the political landscape will now branch out on its own. However, AMA will lend staff and resources to compiling suporting information for the Coalition. Eldon Huston, IMS executive vice president, has represented IMS on a steering committee which will make recommendations regarding the direction of the group's efforts. Minnesota Medical Association will serve as the coalition headquarters.

●**THE MERCY HOSPITAL MIDWEST RURAL TELEMEDICINE CONSORTIUM** and a program of the Iowa Health System are among five telemedicine projects nationally allowed to bill Medicare for services. This pilot project is possible as a result of a waiver and grant funds from HCFA. The projects will focus on two types of medical encounters – medical consultations involving a primary care physician and patients in rural areas and primary care physicians consulting with specialists. Feasibility, acceptability, cost and quality of service provided using telemedicine will be studied.

For more information about any *DEADLINE* news item, call Chris McMahon at IMS headquarters, 515/223-1401 or 800/747-3070.

Iowa Medicine



About the Cover

Rep. Greg Ganske in a publicity photo with Emily Kuster, Johnston, during her family's trip to Washington, D.C. Rep. Ganske is making a bid for his second term in the U.S. House of Representatives.

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When it comes to politics, physicians need to earn their chips and spend them wisely. ● *THE PRESIDENT COMMENTS*

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Iowa's Medicare carrier is auditing E & M coding documentation for the six-month period August – December, 1995.

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On November 5, Rep. Greg Ganske — the first Iowa physician to serve in the U.S. House of Representatives — makes his bid for a seeond term. Rep. Ganske discusses key health care issues in which he has played a significant role. ● *REP. GREG GANSKE*

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The authors discuss the three types of gambling behavior and how to identify pathological gambling in your patients. ● *CHARLES WADLE, DO; JERRY OWENS, LMFT*

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The practice of denying health insurance for "high risk" populations often results in unaffordable premiums for these patients. A UIHC study examines cases from 1986-89. ● *DON VAN DYKE, MD; MARIO PETERSEN, MD, MS; DEBORAH LIN-DYKEN, MD; VIRGINIA MILLER*

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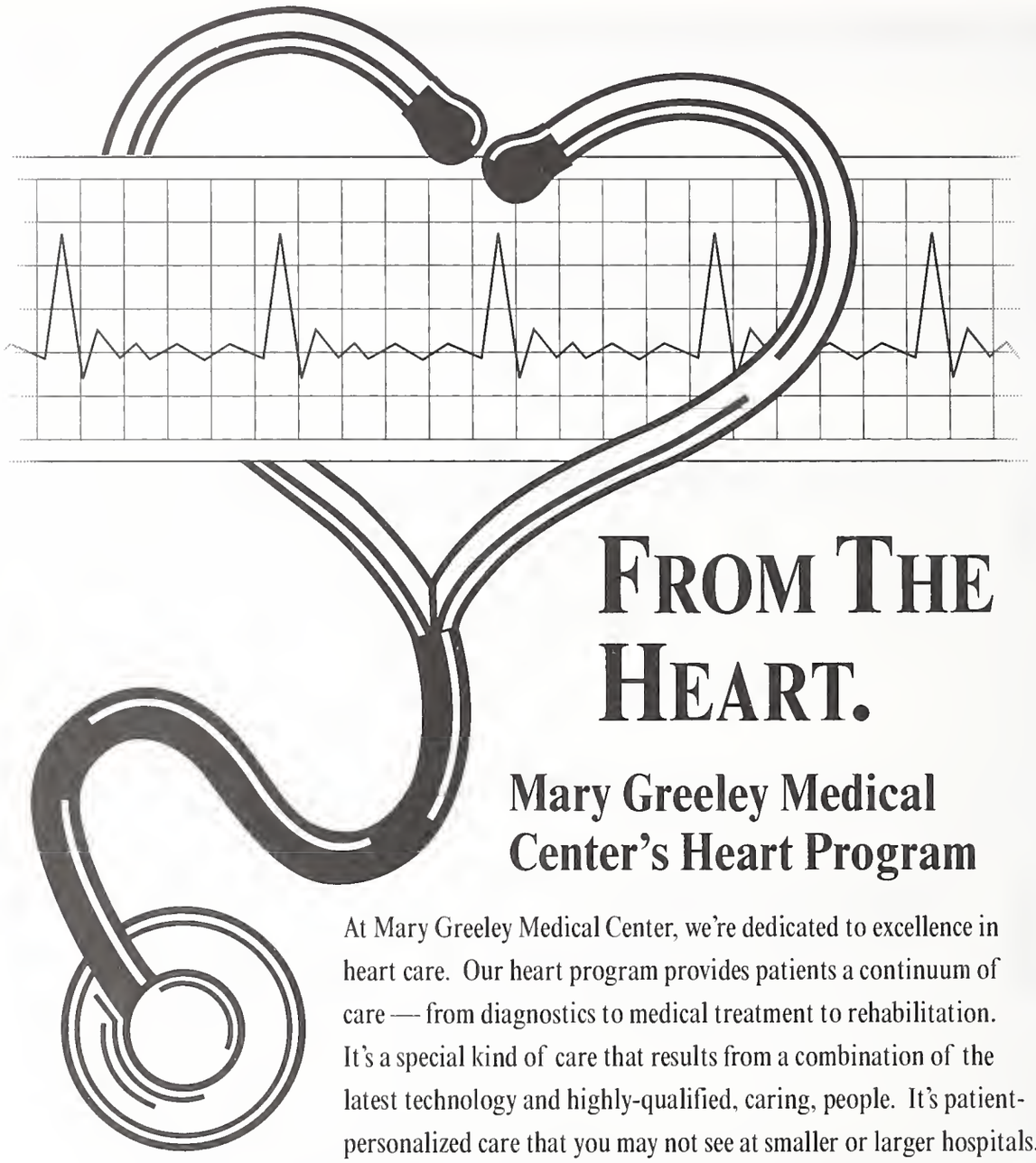
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The "chips" theory

We elected new school board members yesterday. Well, *they* did, *I* was busy. So was Jana. So was most of our town's 18,000 voters. Maybe those 859 people who voted knew something we didn't. Certainly the 15 who attended the debate did. I wonder if the newly-elected members feel their job is that unimportant. Do people just not care if their kids get a good education? I believe most of them feel they can just call these officials later to give advice. Certainly we (physicians) expect our advice to be followed every time we give it.

Most politicians, however, follow the "chips" theory. Being heard and appreciated by a politician begins when you spend chips for access and consideration by your legislator. The chips are a way of adding value to your opinion, weight to your why, right to your reason. They are the currency of past, present and future service to your cause and your candidate.

Early candidate support earns more chips than just jumping in when the race appears to be already decided. Encouraging others in your community to be supportive of the political process is very lucrative in chips and pursuing personal relationships with your legislators is the best way of all.

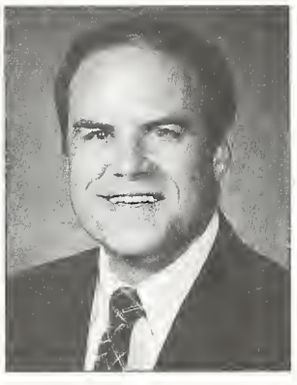
Get to know the people the candidate depends on. These staffers are an important conduit of opinion to your legislator. They can multiple the value of your chips when you start to cash them in.

Probably the most important asset Iowa physicians have in government today is Congressman Greg Ganske. Not because he is a republican and not because he is bright, honest and committed—there are many in Washington who are. But because he is a practicing physician and other politicians seek him out on medical issues. He can have great leverage with the AMA initiatives as he can decide how far to carry their water in a direction that benefits us in Iowa. Who will know better how to strengthen the best parts of Medicare when budgeting gets severe? Discord has always been a privilege of physicians but the lesson to be learned is how to use Ganske chips effectively, in a unified fashion.

Learn to be an effective promoter of legislation and legislators.

Finally, use your own chips wisely. Don't bid against your colleagues. Combine your capital with others and invest your chips with mature understanding of the system and maximum control of the outcome. Just as we learn to impact on patient's lives by learning their home circumstances, learn to be an effective promoter of legislation and legislators. Back the ones that contribute to the long-term good of society and our profession.

Most importantly, vote. Show you care. Be there. IM



William McMillan, MD

MANAGED CARE

news you can use

St. Louis physicians fall victim to 'voodoo' HMO accounting methods

Physician Network Insider advised physicians to guard against voodoo accounting methods by HMOs, citing 1,600 St. Louis physicians who contract with PartnersHMO. An audit revealed that the HMO had withheld nearly $1 million it owed to doctors. Although the doctors contract specified that surpluses were to be divided among physicians, Aetna — the plan administrator — said awarding of the bonus is discretionary. Aetna paid itself $6.65 million for administrative services. The *Physician Network Insider* advises physicians to "scour" quarterly financial reports from the HMO and organize a physician oversight committee.

Court ruling could represent new challenge to managed care

A little-used legal doctrine could give doctors new means to challenge hospital employment and managed care contracts, thanks to a recent Illinois appeals court ruling. The state's fourth district appellate court found that a surgeon wasn't bound by his hospital employment contract because it violated the state's 1923 corporate practice of medicine law. The ruling has "breathed new life" into these antiquated laws, commented one attorney, causing hospitals and other entities to rewrite their contracts with physicians.

Physician input at National Committee for Quality Assurance

Responding to years of criticism from medicine, the National Committee for Quality Assurance will convene a permanent advisory panel of practicing physicians. Critics hope the input will result in more physician-friendly standards from the health plan accreditor.

Integrated systems compared unfavorably to HMOs

A national study indicates hospitals and physician groups that are adding financing components to get into the insurance business are limited in many areas. A survey by Ernst & Young concluded many of the systems have "little infrastructure, unclear commitment from management and are lacking in strategic planning."

Point-of-service popularity will increase, says analysis

Enrollment in fee-for-service plans, which totaled only 5% of the population in 1990, will increase six-fold by the turn of the century, according to an analysis for the National Committee for Quality Health Care. On the other hand, far fewer patients will receive health care under managed fee-for-service arrangements. The percentage breakdowns predicted for the year 2000 by the studies are: Unmanaged fee-for-service — 5%; discounted fee-for-service — 15%; PPOs — 35%; HMOs — 35%; and point-of-service — 30%.

Group practice physicians outnumber solo practitioners

According to an AMA study, physicians employed in large group practices outnumber solo practitioners for the first time. The number of solo practitioners fell to 29.3% by 1994 from 40.5% in 1983. The number of large group physicians rose to 42.3% in 1994 from 24.2% in 1982.

Independence, integration are watchwords for Integra

(Fourth in a series)

Independence and integration are the basic building blocks for Integra Health, a PHO that "makes sense", according to its president Mike Richards, MD.

"HCF is a PHO that functions as a vehicle for the hospitals, doctors and insurance companies to work together," he explains. "Both physicians and hospitals will be part of the health care system of the future, though they may not be structured as they are now."

Offices in over 30 communities

Integra began as Iowa Physicians Clinic in 1988 when three physician groups merged. In 1993, Iowa Physicians Clinic joined the Iowa Health System; three years later, the group is a 200-member primary care medical foundation known as Integra Health.

Integra has offices in 30 Iowa communities and the support of six major hospitals in Cedar Rapids, Des Moines, Sioux City and Waterloo. Integra has primary care physicians in family practice, internal medicine and pediatrics and specialists in endocrinology and diabetes, gastroenterology, infectious disease, neurology, rheumatology, psychiatry, pediatric cardiology and neonatology.

"This began when we looked ahead and knew things were going to change. We wanted to be initiators rather than reactors," Dr. Richards explains. "We didn't have a clear strategy of what to do, we just knew we had to do something."

The group's goal, right from the beginning, was to "become the highest quality, largest primary care group in Iowa," adds Dr. Richards.

"We tried to create a vision of what we wanted to be — not a negative scenario of what we didn't want."

Transitional PHO good for physicians

After plenty of "soul-searching", the original group in the mid-eighties decided a large primary care group would be a good vehicle for the doctors to organize and relate to insurers and hospitals.

Integra's governance structure as an independent affiliate of the Iowa Health System, which is not part of the hospitals, assures that physicians don't lose control of their own destiny. Integra also has an independent board of directors.

The integration which is part of their basic business philosophy provides an avenue for managed care contracting, support for information technology and capital for growth development, Dr. Richards explains.

Integra does not view local physicians as competition, he adds.

"Our competition is poor quality health care, or health care which has poorly-documented quality," he says.

Dr. Richards understands that his role as an MD CEO is a unique one.

"My job is to create an environment where doctors can practice high quality medicine. I know what they need to do that, because I'm a physician. I can help guide the professional staff that supports them."

Grow to 400 physicians

Integra may have begun without a clearly defined goal, but that has changed. The group has three definite goals for the future:

- Have a primary care physician within 30 miles of every Iowan.
- Be the preferred statewide physician group, able to contract with companies on a statewide basis.
- Grow to 400 primary care physicians.

"We have a vision of where we want to be and we all have the same mission," Dr. Richards concludes. "Improve the health of the people of Iowa." IM

We wanted to become the highest quality, largest primary care group in Iowa.

KEY CONTACTS:

Integra Health
515/241-4102

Michael Richards, MD
President/CEO

Dale Andringa, MD
EVP and chief medical officer

James Ziska, MD
EVP and chief administrative officer

Daniel Varnum
Chief operating officer

Robin McNichols
Chief financial officer

If you know of other innovative practice arrangements — especially those controlled by physicians and positioned to compete in the managed care market — call Barb Cannon or Chris McMahon at the IMS, 515/223-1401 or 800/747-3070.

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Please send me an application for membership!

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Address _____

City/State/Zip _____

Telephone Number _____ Number of Physicians _____

IMS Update

GROUP TO LOOK AT IMS STRUCTURE

The IMS is in the process of finalizing appointments to an IMS Governance Task Force which will evaluate the entire governance structure of the IMS in light of the changing health care environment. The task force will meet for the first time on October 10 at IMS headquarters.

The task force will examine how the IMS can do the best job of representing physician groups.

The task force will study the composition of the House of Delegates, the Board of Trustees, the Executive and Judicial Councils. Special consideration will be given to representation for large physician groups in the IMS governance structure and addition of non-voting members to the Board of Trustees. The Governance Task Force is chaired by Donald Kahle, MD, speaker, House of Delegates.

Please call Dean Gillaspey at the IMS, 800/747-3070 or 515/223-1401 with your ideas about improving the IMS governance structure.

IMS Leadership Roundtable

"Common Destiny, Common Goals: An IMS Leadership Roundtable" is scheduled for Wednesday, October 16 from 3:00 p.m. to 8:00 p.m. at the Marriott Hotel in Des Moines.

Approximately 250 invitations went out last month to specialty societies, county societies, the IMS executive council, medical directors of Iowa's 25 largest clinics, IMGMA leadership and county executive secretaries.

The event will give representatives of key physician groups the opportunity to tell IMS leadership about issues which concern them. Attendees will break up into small groups to discuss issues which physicians want the IMS to address.

A special guest at the Leadership Roundtable will be John Knote, MD, vice speaker of the AMA House of Delegates. Dr. Knote will discuss national initiatives by the AMA and collaboration in the federation of medicine. In addition, Rep. Greg Ganske is scheduled to give an overview of congressional action on health care issues.

IMS Directory to be mailed soon

The 1996-97 IMS Directory was mailed out earlier this month. The directory contains a listing of all IMS members and other information about physician practices. It also contains a listing of which IMS staff member to call for assistance in a particular area. For the first time, the directory contains a listing of the largest physician groups in Iowa.

To purchase an extra copy of the directory, contact Sheryal Westbrook at IMS, 515/223-1401 or 800/747-3070.

IMS 1997 dues statements are also scheduled to be mailed this month.

SPECIALTY SOCIETY UPDATE

Over 200 people attended the IOWA MEDICAL GROUP MANAGEMENT ASSOCIATION Fall Meeting in Davenport. The IMGMA Legislative Committee has endorsed the agenda of the Access to Specialty Care Coalition.

The Iowa Psychiatric Society's Ethics Committee has decided to initiate more active investigations of doctors with alleged ethical violations. James Trahan, MD has been nominated for member-at-large and Allen Korbett, DO for secretary-treasurer.

Phillip Habak, MD, president of the American College of Cardiology–Iowa Chapter, will attend the ACC Legislative Conference in Washington, DC this month. The ACC–Iowa Chapter Annual Meeting will be October 19 in Des Moines.

Dr. Mark Gold, a nationally-known speaker on drug abuse, will be keynote speaker at the Iowa Association of County Medical Examiners Annual Meeting November 8 at the Hotel Fort Des Moines.

Appropriate treatment for breast cancer patients will be discussed at the Iowa Oncology Society's Fall Meeting at the Hotel Fort Des Moines November 8.

continued

AT A GLANCE

The Iowa Academy of Family Physicians will present a Skills Development Conference — Managed Care, Leadership and Legislation on October 18-19 at the Embassy Suites, Des Moines. Call the IAFP at 800/283-9370 for more information.

The Iowa EMS Physician Medical Directors Workshop wil be held Friday, November 8 at the Marriott Hotel in Des Moines. For questions or registration, call Steve Mercer, 515/281-4951.

The IMS is in the process of appointing an Iowa physician to the AMA's Coalition for Quality End-of-Life Care. The group will be involved in amicus briefs, press statements, outreach projects and a national symposium on end-of-life issues.

IMS Update

continued

News from Iowa Medical Group Management Association (IMGMA)

Meeting our education needs requires plenty of planning

As chairperson of the IMGMA Education Committee, I have become acutely aware of the varied education needs of our members. Members are located in rural or urban areas; they may work in offices dealing with solo, group or multispecialty clinics or their job roles may vary from office supervisor to clinic administrator. Planning our spring and fall conferences can be a challenge!

The Education Committee examines evaluations from the previous conference for suggested changes in format or design. The committee, which represents a good cross section of our membership, "brainstorms" topic ideas for the conference. Topics that would affect our entire membership are used as a keynote address or general session. The remaining topics are grouped into three tracks. Track I addresses issues that would be of interest to members that are new to their role or the field of health care. Track II addresses issues that would benefit those members who have been in their positions for a period of time and are being challenged by more administrative responsibilities. Track III is for those in an administrative-type role. Top quality speakers usually must be scheduled 12-18 months in advance.

The work involved in planning the conference may sound intensive, but it is the only way that we can ensure our members the quality conference that they deserve. The information, ideas, initiatives and networking that come from the conference are invaluable to our members who are involved in this ever-evolving world of health care management.

(This article was written by Carol Juhl, chair of the IMGMA Education Committee.)

Alliance wants to Stop the Violence

Note: This article was contributed by Karen Messamer, IMS Alliance president.

Wednesday, October 9, is SAVE Today, "Stop Ameriea's Violenee Everywhere". Please join Allianee members aeross the state and nation who are planning aetivities in their eommunities to enhanee publie awareness about this number one health eare erisis in Ameriea. No eommunity is immune from the effeets of violenee.

The dynamie duo of Mary Stewart, IMSA health promotion ehair and Barbara Bell, IMSA eommunity violenee ehair, is taking an aetive role in helping our members plan aetivities and promote publie awareness about abuse and violenee. They're a lot like the Target employees who say, "Ask me, I like to help!"

On September 5, Allianee members eonverged on the Capitol and partieipated in Governor Branstad's signing of the SAVE Today Proelamation.

Here are five aetions you ean take to help stop the violenee:

1. Call Mary Stewart at 515/236-5022 to get a SAVE program kit.
2. Team up with the YWCA's national eampaign "A Week Without Violenee" held the seeond week of Oetober.
3. Call Sandy at IMS headquarters for a eopy of the violenee audio tape produeed by Mary Ellen Kimball and take it to your loeal radio station. Ask them to play it as a publie serviee announeement.
4. View the IMS violenee video, purehase it for $20 then donate it to your loeal library.
5. Adopt a room at your loeal shelter.

Consider these faets on domestie violenee:

•Aeeording to the FBI, a woman is beaten every 12 seeonds in the U.S.

•Over 4,000 women are killed eaeh year at the hands of their batterers.

•33% of battered women suffer from anxiety and depression.

•26% of all women who attempt suieide are vietims of domestie violenee.

•Violenee in the home eosts eompanies an estimated $5 billion.

•70% of ehildren in homes of batterers are themselves abused and negleeted.

Remember—violenee has replaeed disease as the number one killer of ehildren in Iowa.

We, the 1,100 IMSA members aeross the state of Iowa, ean have a huge impaet in arresting this epidemie of violenee by partieipating in SAVE Today. IM

Legislative Affairs

IMS committee discusses point-of-service

The first meeting of the 1996 IMS Legislative Committee September 10 was devoted to managed care issues, specifically, implementation of an IMS House of Delegates resolution relating to point-of-service.

Last April, the IMS House passed a resolution calling for an optional point-of-service feature in all health plans. This would allow patients to self-refer to physicians outside the plan at additional cost to themselves.

The IMS Legislative Committee discussed options for implementing this resolution:

1. The IMS would file a bill and act as the lead organization on the issue; or
2. The IMS would work in conjunction with the Iowa Alliance for Quality Health Care (the business coalition) and/or the Iowa Alliance for Continuing Access to Specialty Care (a coalition of specialty representatives); or
3. Look for opportunities to amend our proposal to other bills.

Considerable concern was expressed among committee members that any bill introduced by the Iowa Medical Society could evolve into an any willing provider bill. However, committee members stressed that there will be significant grassroots support among physicians for point-of-service legislation.

The committee will recommend that the IMS work with the Iowa Alliance for Quality Health Care on a point-of-service bill in the 1997 Iowa Legislature.

If IMS cannot reach an agreement with this business coalition, IMS will introduce its own point-of-service bill. The committee's recommendation was approved by the IMS Board of Trustees at its September 19 meeting.

Committee members pledged that whenever possible, IMS legislative activities will be coordinated with the Iowa Alliance for Continuing Access to Specialty Care.

At its next meeting in November, the IMS Legislative Committee will consider a prohibition on gag rules and a requirement that physician and nurse reviewers be licensed in Iowa which could be added to the point-of-service bill. The committee will also consider other issues which may be of interest to Iowa physicians during the 1997 legislative session.

IMS supports "smokeless" states grant

The Iowa Medical Society has pledged support for a Smokeless States grant proposal being submitted by the Iowa Tobacco Free Action Team.

Among other measures, the grant will provide money for local enforcement of anti-tobacco laws, particularly those which affect young people's access to tobacco.

continued

AT A GLANCE

The AMA has filed a brief with the US Supreme Court asking for a ruling on the constitutionality of physician-assisted suicide.

The Iowa Department of Public Health recently amended the Iowa Code on child immunizations to include new requirements for preschoolers for Hib vaccine and measles and rubella vaccine. Call Bev Corron at the IMS for a faxed explanation of the new requirements. The amendments allow Iowa to comply with national standards set by the American Academy of Pediatrics and the Immunization Practices Advisory Committee.

IMS STAFF WILL 'MAKE THE ROUNDS' WITH MEMBERS THIS FALL

Members of the IMS staff will be making the rounds this fall to speak with IMS member physicians in hospital staff lounges, large clinics and at county medical society meetings. Staff will be prepared to discuss IMS 1997 legislative priorities, data projects, coding and reimbursement issues and a myriad of other issues affecting Iowa physicians today. It is hoped that the agenda — particularly in hospital and large clinic lounges — will be more informal. In short, IMS staff want to discuss anything that is on the minds of Iowa physicians.

To arrange for a visit in your area, call Paul Bishop at the IMS, 515/223-1401 or 800/747-3070.

Legislative Affairs
continued

Thank you from IMPAC!

Both the quality of medical care and the quality of medical practice can be affected by the actions of just a few legislators. They need to know that medicine is united and involved.

Many thanks to all Iowa physicians who responded to the recent solicitation from IMPAC, the Iowa Medical Political Action Committee. In this election year, it is vital that physicians both vote and participate in election campaigns. The easiest and most minimal level of campaign participation is a generous contribution to IMPAC/AMPAC.

If you haven't done so, please send your personal check to IMPAC. For more information, call Paul Bishop at IMS, 515/223-1401 or 800/747-3070.

AMA actions on fraud/abuse provisions

(Excerpts from recently-released statement on the just-passed health care reform bill.)

The AMA opposes fraud and abuse in the health care system. But, it believes the answer to the problem is not turning enforcement into a legal and professional nightmare for honest physicians and not to treat paperwork mistakes as criminal acts. There was a chance that could happen if certain language had been adopted.

However, firing broadsides at fraud and abuse provisions in hopes of sinking them would have been a losing strategy. Instead, AMA worked to achieve a realistic goal — getting the right language adopted in the final bill.

AMA provided members with access to the lawmakers' offices via a toll-free hot line; 4,000 connections were made. Due in large part to AMA efforts, the "knowing and willful" language was included in the final version of the bill.

Also in the final legislation is a provision pushed by AMA that would give physicians the right to get an advisory opinion from the government before they undertake specific practice arrangements.

It may not be the stuff of headlines, but these changes — and the effectiveness of organized medicine in advocating for them — are very good news for physicians. IM

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Medical Economics

Some hospitals could drop clinics

Many hospitals may drop their clinics as a result of a recent decision by HCFA to tighten the definition of provider-based outpatient centers, according to a recent issue of *Modern Healthcare*.

In the past, HCFA has taken the hospitals' word for the status of outpatient clinics, but that is about to end. HCFA is expected to release guidelines in the form of a proposed regulation next spring.

HCFA officials intend to stop government funds to hospitals which have abused the provider-based designation. In particular, HCFA points the finger at providers who have purchased physician clinics in areas far from the hospital and designated the clinics as "outpatient departments".

The new policy will likely require hospitals to show that the outpatient clinics are in close proximity to the hospital and have a common licensure, common accreditation and common ownership.

Those losing the designation will likely spin off their outpatient centers into free-standing clinics or independent medical foundations to avoid extra administrative costs and stricter licensing reviews.

The *Modern Healthcare* article contains criticism from at least one health care lawyer who said HCFA's actions "demonstrate the agency doesn't understand how integrated delivery systems are developing".

Who owns health care?

Despite a recent stampede by health care companies to convert their ownership to for-profit status or join investor-owned companies, a significant portion of the delivery system remains in nonprofit hands, according to data from industry surveys.

More than 90% of physician group practices are nonprofit organizations, as are nearly 85% of the nation's acute care hospitals. In the fast-growing HMO sector, however, nearly 75% are investor-owned. Nearly 50% of psychiatric hospitals and 71% of nursing homes are investor-owned.

Antitrust guidelines revised at last

Persistence has paid off for organized medicine. In case you missed a special mini-message sent last week to IMS members, revisions of the antitrust guidelines have been released by the Federal Trade Commission and the Department of Justice. The new guidelines incorporate important points for which the AMA has consistently lobbied.

The revisions are a significant step forward in ending the discrimination of prior agency policies against physician joint ventures.

In revising the guidelines, the two agencies "acknowledged the fundamental changes in the health marketplace, in particular the power of insurance companies and employers, and the benefits to patients of ventures designed and controlled by physicians".

For the first time, noncapitated physician joint ventures will be judged by the rule of reason rather than being viewed as *per se* illegal when a single price for services is agreed upon. The new statement says it is "unlikely" that joint ventures in competitive markets will raise substantial antitrust concerns.

Networks as large as 50% of market physicians will be viewed as reasonable in competitive markets if they are non-exclusive and meet standard joint venture criteria.

Capitation on trial in Oklahoma

The theory of capitation is on trial in Oklahoma City. At the heart of the medical negligence suit is the plaintiff's contention that an HMO and its capitated physician group breached their fiduciary duty to a patient by denying necessary care. IM

AT A GLANCE

Pilot projects are testing the idea of integrating Medicare and Medicaid payments for long-term care services to frail elderly who qualify for both programs. A Minnesota project aims to reduce inefficiencies caused by different financial incentives and delivery systems. Physician acceptance is a question.

Columbia/HCA is considering entering the medical malpractice insurance market. The hospital giant is currently undertaking a pilot project insuring 150 physicians in several markets. If Columbia decides to enter the market, it would provide serious competition for St. Paul Fire and Marine, the nation's largest malpractice insurer.

New mothers in New Jersey are making drive-through deliveries a thing of the past. Since a law was passed banning drive-through deliveries, women have stayed in the hospital 10-12 hours longer.

DATA & TECHNOLOGY

"Physicians need periodic feedback on their performance compared with that of colleagues to improve quality in their practices."

R. Heather Palmer, MB, BCh
Harvard School of Public Health

Diabetic care

According to HCFA's Ambulatory Care Quality Improvement Project, 39% of diabetic patients did not receive a dilated eye exam; 56% did not receive a foot exam. The study was conducted during January, 1994 to June, 1995 and involved physicians in Iowa, Alabama and Maryland.

Interpret data with care

The Health Management Information Center, in one of its last activities as contractor for the now-defunct Iowa Health Data Commission, has released the report "**Using the Link between Data and Health Care Decisions**". The report contains charge and mortality data for two heart surgical procedures — cardiac valve procedure and coronary artery bypass graft.

The report singles out Mercy Hospital, Iowa City, as having a significantly higher mortality rate for both procedures. However, the medical staff discovered documentation was lacking for complicating conditions, which would have favorably decreased the hospital's risk-adjusted mortality rate. This is a classic example of how collecting and analyzing data can be problematic. Interpretation must be made with care.

Study of outpatient origin

The Association of Iowa Hospitals and Health Systems (IH & HS) — in conjunction with the IMS — has released the first **Outpatient Origin and Destination Study**. It involves data on 32 outpatient procedures performed in participating hospital outpatient departments, physician offices and ambulatory surgical centers.

Results for July–December, 1995 show where patients come from and where patients residing in a particular county go for these procedures. Customized reports which sort each procedure by attending physician UPIN and by county or facility can be purchased by contacting Ed Whitver of the IMS staff.

Free quality improvement packet from IFMC

The Iowa Foundation for Medical Care (IFMC) has initiated several voluntary projects through funding provided by HCFA's Health Care Quality Improvement Project. Hospitals are given a free Project-in-a-Box packet containing background information, data abstraction tools, software and current quality indicators to help hospitals and medical staffs plan and implement quality improvement activities.

Project topics include blood transfusion, congestive heart failure and pneumococcal and influenza immunization rates. Future topics will address carotid endarterectomy, hip fractures, myocardial infarction, atrial fibrillation, hearing impairment and TIA/stroke. Physician involvement is critical to the success of these projects at the local level. For more information or to receive a Project-in-a-Box packet, contact Becky Hemann, IFMC vice president, at 800/383-2856. IM

For more information, call Ed Whitver, IMS manager of health care data and technology, 515/223-1401 or 800/747-3070.

Policy on telemedicine licensure

The IMS Telemedicine Task Force is leaning toward following AMA policy to require full state licensure for any physician providing medical care through telemedicine. Infrequent consultations with specialists, a common occurrence, would be the exception.

This position is contrary to model regulation developed by the Federation of State Medical Boards, which calls for a physician to obtain a special license issued by the state medical board, limited to the practice of medicine across state lines.

Practice Management

Clarifying billing problems

The Department of Human Serviees, Unisys and MBC are issuing provider releases elarifying billing problems and payment polieies. Physieians should reeeive these direetly from the two eompanies.

If you provide serviees paid by Title 19 or BMC for mental health or substanee abuse, please read the releases earefully. The releases address many issues IMS has worked hard to resolve through intense advoeaey efforts with the DHS, Unisys and MBC.

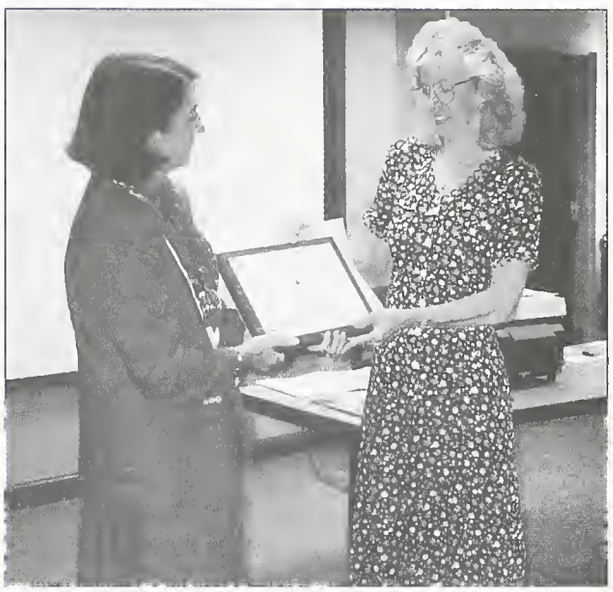
The releases are identified as follows:

DHS/Unisys — All Provider Release No. 177

MBC — Mental Health Release No. 7 (MHAP)

MBC — Substanee Abuse Release No. 1 (IMSACP)

If you have any questions about the provider releases, eall Barb Cannon at the IMS, 515/223-1401 or 800/747-3070.



Laureen Jellema (at right), an insurance clerk at the Family Practice Center in Mason City, receives her Medical Business Specialist plaque from Barb Cannon, IMS director of medical economics. Ms. Jellema was certified as a Medical Business Specialist in July.

continued

When Bad Things Happen to Good People

WHY YOU NEED A BILLING COMPLIANCE PROGRAM

If you read the article on page 317 of this *Iowa Medicine*, you know Medicare audits are underway in Iowa. On Wednesday, December 11, IMS Services will offer a special workshop entitled "When Bad Things Happen to Good People — Why You Need a Billing Compliance Program". The workshop deals exclusively with audits and compliance programs.

The program will be offered over the Iowa Communications Network in 25 locations around Iowa from 6:00 p.m.–9:00 p.m. Faculty will be billing expert Michael Reiling of Partners Consulting Groups, Ltd. and health lawyer David Glaser, JD. They will explain how you can establish a compliance plan that will keep your office out of trouble and how to respond to any investigation of your practice if trouble arises.

The cost of the workshop is $69. It will be offered in the following cities (watch the November/December *Iowa Medicine* for exact locations):

Atlantic	**Jefferson**
Burlington	**Johnston**
Cedar Rapids	**Keokuk**
Clinton	**Marshalltown**
Council Bluffs	**Mason City**
Davenport	**Muscatine**
Des Moines	**Ottumwa**
Dubuque	**Spirit Lake**
Fort Dodge	**Sioux City**
Iowa City	**Waterloo**

For more information about this important IMS Services workshop, call Sherry Johnson at the IMS, 800/747-3070.

AT A GLANCE

There has been a sharp increase in complaints of sexual harassment on the job. Over 15,000 claims were filed with the EEOC last year, up from 6,000 in 1990. Be sure you have a written company policy in your employee manual. Spell out the procedure for making complaints. Management can be liable even if it doesn't know of violations, for example, dirty jokes, sexual innuendos or photos that would offend a "reasonable" person. Employers must act decisively when confronted with a complaint.

The Centers for Disease Control is expecting a rough flu season, says the Kiplinger Newsletter. *The Beijing, Texas and Wuhan strains will show up in mid-November. CDC is recommending shots for older people and those with chronic illnesses.*

Practice Management
continued

One of the most frequent problems in defending malpractice claims is omission of critical documentation in the medical record.

MIDWEST MEDICAL INSURANCE COMPANY • FOCUS ON RISK MANAGEMENT

Problems with medical records: omitted documentation

A woman called her physician's office complaining of vomiting and diarrhea. She spoke with a nurse who recommended routine flu care and a clear liquid diet. The next day she seemed to feel better and called the clinic again asking what foods she could eat. A nurse recommended a bland diet. Neither conversation was recorded in the patient's chart; the physician was not consulted.

The next evening, her boyfriend called the emergency room and described flu-like symptoms to a nurse, who relayed the message to her physician. The physician returned the call and discussed the woman's symptoms with the boyfriend. The physician recommended that if she continued to have difficulties she should come to the hospital. Again, this conversation was not documented in the medical record. She continued to vomit and have diarrhea the next day, but no further calls were placed to her physician. She died during the night of a ruptured appendix. A malpractice claim was filed alleging the physician failed to diagnose the patient's condition.

One of the most frequent problems in defending malpractice claims is the omission of critical documentation in the medical record. It can be difficult to dispute allegations about telephone conversations without documentation in the medical record.

Deficiencies in documentation can have significant consequences in the following areas:

- Causing of patient injuries — Many patient injuries occur because of errors, omissions, illegible entries and other medical record problems that preclude physicians and other caregivers from rendering appropriate treatment.
- Filing of claims — In determining whether or not to initiate a malpractice claim, plaintiff attorneys scrutinize the record for evidence of the appropriateness of care.
- Defense of claims — Experts have estimated that the defense of 35-45% of all claims is jeopardized by problems with the medical record documentation.

For more information contact Lori Atkinson, MMIC risk management supervisor, Midwest Medical Insurance Company, West Des Moines Office, PO Box 65790, West Des Moines, Iowa 50265, 800/798-9870 or 515/223-1482.

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At least five IMS members involved . . .

Medicare audits underway

In late August, it came to the attention of the IMS that Iowa's Medicare carrier has been auditing E & M code documentation for the six-month period August-December, 1995, immediately after the education period on required documentation guidelines ended.

In response to a mini-message sent to IMS members, five Iowa physicians notified IMS that they are being audited. Medicare has requested paybacks from these physicians ranging from $6,000 to $72,000.

IMS staff have been unable to confirm that similar Medicare audits are underway in any state except Iowa.

Thirty days to choose an option

In Iowa, the Medicare carrier is allowing physicians to choose one of the following three options for settlement:

#1 Repay the money, admit you made billing errors, waive all your rights to appeal.

#2 Admit you made errors, waive your rights to appeal, request a meeting to discuss the findings, then repay the money (or, some lesser amount determined after the meeting).

#3 Don't pay the money, don't admit any errors, don't waive any rights, ask Medicare to reaudit a statistically valid sample and agree to pay based on those findings (amount could be more or less than the original repayment amount).

Regardless of the option chosen by the physician, it is almost certain that every audited physician will be reaudited after the first audit is settled to assure the problem is resolved. Fines and sanctions could be imposed at that time in addition to further repayments if Medicare determines that problems were not addressed and corrected. In addition, findings can be projected over a larger time frame than six months.

What should you do?

IMS offers one very important piece of advice to any physician notified of a Medicare audit: ***Do not sign anything until you consult an attorney who specializes in such matters!***

In addition, physician office staff who receive notification of a Medicare audit (or a request to send patient records to Medicare) should be sure and tell the physician. If the audits involve services in the hospital, the record request will go to the hospital directly with a copy of the letter to the physician. Hospitals should notify physicians of any requests for their patients' records.

It is very important to keep copies of everything which you receive from the Medicare carrier and everything sent from your office.

Physicians should personally review materials to be sent to Medicare and be sure all relevant records are included. A cover letter to help with standard abbreviations, shorthand notations or specialty specific terms might be useful to the carrier.

Also, physicians should ask the Medicare carrier for a written response on the final results of the audit in a specified time frame.

Finally, you want to be certain that all future documentation is complete. Consider having an expert review your documentation.

The IMS may be able to provide some technical and staff assistance to members. Call Barbara Cannon at the IMS, 515/223-1401 or 800/747-3070.

IMS program on December 11

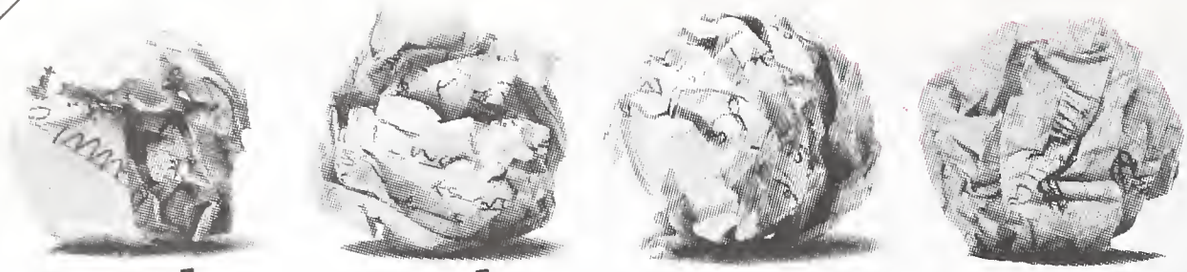
On December 11, the IMS will have a program on the ICN entitled **"When Bad Things Happen to Good People — Why you need a Billing Compliance Program."** This program will deal exclusively with audits and compliance programs. Featured speakers will include an attorney who has worked with numerous audits, including some in Iowa, and a medical practice consultant.

The program will be held in the early evening at 25 locations around Iowa. IM

Do not sign anything until you consult an attorney who specializes in such matters.

The March, 1996 issue of Iowa Medicine *contained an article entitled* 500 FBI AGENTS. *This article contains advice from an attorney on Medicare coding audits. If you do not have a copy, call Bev Corron at the IMS, 800/747-3070.*

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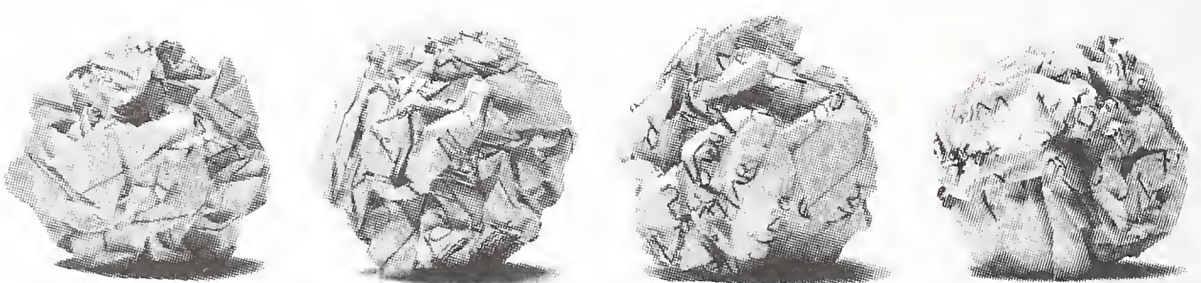
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Newsmakers

"My days at UNMC —a wonderful experience"

Letter to the Editor

Dear Friend:

Today, I informed President Smith that I intend to resign from the position of Chancellor of the University of Nebraska Medical Center effective September 30, 1996. Former President Martin Massengale hired me under the model of Chancellor as Chief Executive Officer of the campus. That model, which called for strong leadership at each campus, is now changing. While other management systems are valid, my interests and abilities are best suited to the CEO role.

My days at UNMC have been a wonderful experience. I feel proud of what we have accomplished together during my time here. We brought the decade-long dream of a student center to reality, got the Lied Transplant Center started and paved the way for construction of critically needed laboratory research space.

We looked hard at the institutional culture and began the journey to transform UNMC into a customer-focused, flexible, innovative, more inclusive and cost-effective organization. With colleagues, I laid the foundation for a strong partnership with Alegent. Now it will be up to President Smith and the Board of Regents to support UNMC in developing the partnerships that are essential to survival of the academic mission.

I came to UNMC because I saw a core group who was committed to finding a better way. The vision of a better future for students, patients, employees and the constituencies we serve is strong at UNMC.

It is true that I nurtured this collective vision, articulated it over and over again and developed people who could lead the way at all levels in UNMC. The vision is way beyond me now and I believe that truly committed people of UNMC will never go back to the "old ways."

Over these last months, UNMC has been beset by "storms" of conflict. Much of this storming is a critical struggle about old ways and the emerging culture. It is essential that people now come together to focus on the core of our UNMC mission—service to others in order to improve health.

I leave my position knowing that a marvelous legacy of people will continue the important work we have begun together. I plan to take a year-long leave of absence to work on several future-oriented projects and look for the next challenging opportunity.

A special thanks to the many who have given me encouragement and support—it was so important and so much greater than any leader could expect. In these last few difficult months, by your actions and words, you have given me a rare gift—the opportunity to see the impact of my own work. I am confident that you will keep the vision of service alive.—*Carol Aschenbrener, MD (Note: Dr. Marion Alberts received this letter which was sent to a number of Dr. Aschenbrener's friends and colleagues.)*

IAFP elects officers, award winners

Dr. Tom Evans, Johnston, was elected president of the Iowa Academy of Family Physicians at the Annual Meeting and Scientific Assembly held August 21-24 in Des Moines. Other newly-elected officers include **Dr. John Carroll**, Carroll, president-elect; **Dr. George Kappos**, Ankeny, vice president and **Dr. Sheila Sawyer**, Cedar Rapids, secretary-treasurer. **Drs. David Kresnicka**, Marion; **Don Marquardt**, Cedar Rapids; **Susan Langbehn**, Iowa City and **Lynette Illes**, Washington, were elected to the board of directors. **Dr. Robert Christensen**, Carroll, was elected delegate to the American Academy of Family Physicians; **Dr. Laine Dvorak**, Humboldt, was elected alternate delegate. Also at the meeting, **Dr. Alan Vasher**, Ida Grove, was honored as Iowa Family Doctor of the Year; **Dr. Kim Brandt**, Mount Vernon, was honored as Family Practice Educator of the Year. IM

AT A GLANCE

Dr. William Galbraith, who practiced internal medicine in Cedar Rapids for many years, is featured in a new book, The 50 Most Positive Doctors in America. *He was chosen from among more than 300 nominees.*

John Forsyth has been named the new CEO of Blue Cross Blue Shield. He will address the IMS Board of Trustees and the Executive Council at IMS headquarters in January.

Ganske concerned about effects of managed care

Greg Ganske, the first Iowa physician in the U.S. House of Representatives, is making his bid for a second term. Although he is consistently complimented by the AMA for his efforts on health care legislation, Rep. Ganske was recently listed by the Wall Street Journal *as one of 13 "endangered freshmen". Iowa Medicine invited Rep. Ganske to discuss accomplishments in the health care arena during his first term.*

The 104th Congress has been memorable for many reasons, not the least of which are the health care issues which drew my attention. One of the most important issues I have worked on concerns safeguarding patients enrolled in the managed care system.

Patients must know treatment options

Patients need to know all of their medical treatment options. Unfortunately, some health plans now attempt to keep health care providers from sharing all the information about those options.

The Patient Right to Know Act would ban "gag rules" which some health plans have used to keep patients from learning what they need to know about the treatment of their illness.

The Patient Right to Know Act was unanimously approved by the House Commerce Committee, of which I am a member. The bill has over 140 bipartisan cosponsors and was recently endorsed by the President. Even before final passage, the bill has had the positive effect of prompting some health plans to institute changes on their own.

Another legislative initiative which I believe is very important for physicians and their patients is my effort to eliminate patents on medical and surgical procedures.

In 1994, he was awarded a patent. This breast reconstruction procedure, however, had been in widespread use for at least 15 years.

Procedural patents are a growing problem

Patents on medical and surgical procedures increase health care costs, limit patient access to care, are contrary to the Hippocratic Oath and hamper the development of medical advances worldwide.

Procedural patents are a burgeoning problem, growing in both number and type. An estimated



REP. GREG GANSKE
Greg Ganske is seeking his second term as fourth district U.S. Representative. He serves on the House Commerce Committee. Rep. Ganske is a reconstructive surgeon in Des Moines.

100 such patents are issued each month. More alarming is the growing number of doctors trying to enforce these patents and collect royalties on their "invention".

The validity of the patent is based on three elements: utility, novelty and non-obviousness.

A plastic surgeon applied for a patent on a procedure he entitled "A Method for Total Immediate Post-Mastectomy Breast Reconstruction Utilizing a Latissimus Dorsi Myocutaneous Flap." It sounded novel to the Patent Office so, in 1994, he was awarded a patent. This breast reconstruction procedure, however, had been in widespread use for at least 15 years before 1994. In fact, this is the type of breast reconstruction my mother had years ago.

A prohibition on medical procedural patents would stop such outrageous abuses of the system.

Common-sense insurance reform

The 104th Congress passed common-sense health insurance reform. Many Iowans find themselves locked in a job because leaving means having to negotiate a change in their insurance. This is especially difficult for families with children with special needs.

The health insurance reform bill that passed Congress will allow people who change jobs to immediately access their new employer's health care coverage or to buy individual insurance. This will free as many as four million people from job lock. The bill also limits the ability of insurance companies to deny coverage to people who have preexisting conditions and increases the tax deductibility of health care expenses for the self-employed.

Improving women's health

Of special personal significance to me are steps we have taken to improve women's health. As I have mentioned, my mother is a survivor of breast cancer and I have treated hundreds of women with breast cancer. I know all too well the pain and sorrow caused by this disease.

Of special personal significance to me are steps we have taken to improve women's health.

In 1996, breast cancer research at the Department of Health and Human Services is funded at more than $470 million, nearly double the 1993 level. In addition, the defense budget includes $100 million in funding for breast cancer research and another $25 million for mammograms for women in uniform.

I have cosponsored legislation that would require health plans to cover two-day hospital stays for normal deliveries and four-day stays for caesarean sections. *The Des Moines Register* has reported on the problem of new mothers and newborn babies being forced out of the hospital too soon. Infants are then rushed back to the hospital for emergency treatment of jaundice or other problems.

Similar legislation recently passed the Senate and I hope that this important reform

continued

continued

will pass this month.

The House Commerce Committee ended 15 years of gridlock by passing desperately needed pesticide reform, not normally thought of as a health care issue. Supported by agriculture, consumer and environmental groups, this measure allows safer, more effective pesticides to be used and provides special protections for infants and children.

This measure allows safer, more effective pesticides and provides special protections for infants and children.

Wants more common-sense reform

I believe these accomplishments in the areas of health care are a good beginning. As long as I am the representative of the Fourth District of Iowa, I will continue to play a leadership role in bringing about common-sense reform in health care. IM

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Just the basics

At the start of the 1980s, the reigning media investment superstar was Joe Granville. When he told his followers to sell everything, many of them stampeded to the exit door causing the Dow Jones Industrial Average to fall more than 3%. At the start of the great 1980's bull market, he advised his followers to "go short" (selling shares with the anticipation of buying them back later at lower prices) in expectation of profiting when the market collapsed. After missing the major market advance of the early 1980s, he finally turned bullish . . . right at the top of the market before the crash of 1987.

There have been many other 'experts' before and after Joe Granville. Market gurus come and go because it is impossible to predict future market movement with consistent accuracy. This is one of the reasons that a majority of stock mutual funds have underperformed the general market averages. Performance leadership among mutual funds is constantly rotating. The market is so volatile that this year's fund winners may very well be next year's losers. Numerous academic studies have shown that very few funds can consistently perform in the top ranks year after year.

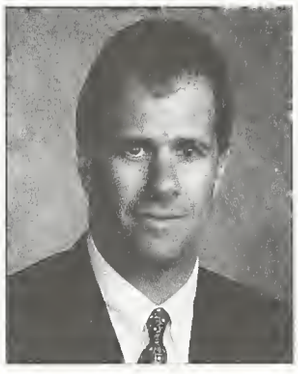
The market is so volatile that this year's fund winners may very well be next year's losers.

So, what is the answer to putting together a portfolio that will meet your investment and personal objectives? A study conducted in 1981 by Brinson, Singer and Beebower showed that over 90% of a portfolio's return can be attributed to the asset allocation, while less than 10% is due to security selection and market timing. However, most managers and investors will spend most of their time trying to pick the right security or trying to determine when is the right time to buy.

Asset allocation is a process of balancing a portfolio with various classes of investments such as U.S. stocks, foreign stocks, bonds and real estate. Changing the allocation will adjust the volatility and return of the portfolio. Allocation works because different assets move up and down in value independently of one another so while one class is going down, another is going up.

The most effective way to implement this kind of portfolio startegy is to use "asset class" funds and indexed funds that will mirror the performance of a specific asset class. Not only will they more reliably deliver the performance of the asset class (something actively managed funds have difficulty doing), but they are less expensive, with management fees running about one-third of those charged by actively managed funds.

It's important to tailor an asset allocation strategy to your needs, factoring in issues like time horizon, risk tolerance and return expectations. Once that is established, stick with it regardless of what happens in financial markets. This kind of discipline will pay high dividends. IM



JERRY FOSTER

Jerry Foster is the founder and president of Foster Capital Management, a fee-based financial advisory firm endorsed by the Iowa Medical Society. Mr. Foster can be reached at 1-800/798-1012.

CME Seminars

AT A GLANCE

Advertise your continuing medical education seminars or workshops in this section by calling Jane Nieland or Bev Corron at the Iowa Medical Society, 515/223-1401 or 800/747-3070, fax 515/223-8420 or send copy and payment to Iowa Medicine, *1001 Grand Avenue, West Des Moines, Iowa 50265. Cost is $25 per insertion up to 10 lines. Deadline is the first of the month preceding publication.*

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Who hasn't thought about retirement? However, few of us plan conscientiously. Whether you are looking to retire at 55, 60, 65 or later, your success will depend on planning. You may have questions such as:

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The Journal
of the Iowa Medical Society

Pathological gambling

● CHARLES WADLE, DO; JERRY OWENS, LMFT

Whether it is bingo, pari-mutuel and simulcast wagering on horses and dogs, lotteries, slot machines, casino table games, card games, video gambling, sport pools, commodities or the stock market, gambling by Iowans has rapidly expanded during the last 10 years. Eighty-eight percent of adult Iowans participated in a gambling activity during 1995.[1]

The three classes of gambling behavior are social gambling, problem gambling and pathological gambling. The large majority of those who participate are social gamblers who gamble for pleasure, companionship and entertainment. Their sense of self does not depend upon winning. Losses are viewed as acceptable. They are rarely preoccupied with gambling and are not prone to take risks when under financial risk.

The problem gambler falls short of diagnostic criteria for pathological gambling but is at significant risk to develop such a pathology. These individuals would score three or four on the South Oaks Gambling Inventory or meet three or four of the diagnostic criteria for pathological gambling in the Diagnostic and Statistical Manual IV (DSM IV).[2]

The essential feature of pathological gambling is persistent and recurrent maladaptive behavior that disrupts personal, family or vocational pursuits (see boxed sidebar on the next page) or a score of five or more on the South Oaks Gambling Scale or meet Diagnostic and Statistical Manual (DSM IV) criteria.[3]

Prevalence, gambling options both increase

Limited data describe variance in estimates of problem and pathological gambling. The DSM IV reports 1–3% of the adult population may be pathological gamblers. Others believe 5% is more representative as gambling options in the United States are increasing. Jacobs describes rapidly increasing rates of problem gambling among adolescents. His data estimates 4% of adolescents display patterns consistent with pathological gambling.[4]

R. A. Volberg completed demographic surveys regarding gambling behavior in Iowa during 1989 and 1995. Table 1 shows the point estimates and standard deviations for the combined prevalence rate of lifetime problem and probable pathological gambling for the 1989 and 1995 samples. Table 1 also shows the point estimates and standard deviations for the combined prevalence rate of lifetme problem and probable pathological gambling in Iowa in 1989 and 1995. Clearly, there has been a significant increase in the prevalence rate of lifetime problem and probable pathological gambling in Iowa between 1989 and 1995.

Common characteristics and co-morbidity

Pathological gamblers often share the following behavioral and cognitive patterns as defined by M. C. McGurrin:

1. Vacillation between periods of extreme self-confidence and acute self-doubt, depression and anxiety.

TABLE 1
COMPAREING LIFETIME PREVALENCE ESTIMATES, 1989 AND 1995

Prevalence	*1989 (N-750)*	*1995 (N-1,500)*
Lifetime probable pathological	0.1% (±0.2%)	1.9% (±0.6%) **
Lifetime problem	1.6% (±0.8%)	3.5% (±0.9%) **
Lifetime prevalence	1.7% (±0.9%)	5.4% (±1.1%) **

* *Significant ($p \leq .05$)*
** *Highly significant ($p \leq .01$)*

The IMS Education Fund has designated this article as the Henry Albert Presentation Award for October 1996.

CHARLES WADLE, DO
JERRY OWENS, LMFT
Dr. Wadle, a Des Moines psychiatrist, is medical director for Mercy First Step Recovery Program. Jerry Owens is a therapist with Wadle & Associates, P.C.

Pathological gambling

continued

2. A view of reward and achievement through sustained effort and delayed gratification as an inferior means of financial self-support.

3. A tendency to have difficulty in maintaining intimate and supportive relationships with family members.

4. A belief that the outcomes of significant life events are externally controlled. (A more realistic internal orientation toward control and responsibility is an essential goal to overcome this problem.)[5]

For a copy of the complete South Oaks Gambling Inventory, call Bev Corron at the IMS, 800/747-3070 or 515/223-1401.

Increased rates of depression, attention deficit disorder and substance use are associated with pathological gamblers. Also antisocial, narcissistic and borderline personality disorders (cluster B) occur at a higher rate.[6]

Typical male problem gamblers tend to gamble for the action; women are more likely to gamble to escape.

Both sexes develop patterns of distorted thinking and unrealistic expectations to justify the ongoing unresponsible and self-defeating behaviors.

They are prone to develop general medical conditions associated with chronic stress. Examples include hypertension, peptic ulcer and migraine headaches. The rate of suicidal behavior is significant as survey data of gamblers in treatment report 20% have attempted suicide.[3]

Diagnostic criteria for pathological gambling

Persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:

1. **Is preoccupied with gambling (e.g., preoccupied with reliving past gambling experiences, handicapping or planning the next venture or thinking of ways to get money with which to gamble);**
2. **Needs to gamble with increasing amounts of money in order to achieve the desired excitement;**
3. **Has repeated unsuccessful efforts to control, cut back or stop gambling;**
4. **Is restless or irritable when attempting to cut down or stop gambling;**
5. **Gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression);**
6. **After losing money gambling, often returns another day to get even ("chasing" one's losses);**
7. **Lies to family members, therapist or others to conceal the extent of involvement with gambling;**
8. **Has committed illegal acts such as forgery, fraud, theft or embezzlement to finance gambling;**
9. **Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling;**
10. **Relies on others to provide money to relieve a desperate financial situation caused by gambling.**

Treatment options

Iowans with gambling problems can be referred for treatment by telephoning 1-800/BETS-OFF. Family members can also receive referral. This hotline provides information regarding outpatient licensed treatment programs which serve their geographical area. There are seven state-funded programs in Iowa. These programs utilize the 12 steps of Gamblers Anonymous, psychoeducation and group/individual counseling to assist clients and family members.

Some gamblers and family members will need psychiatric services to address co-morbidity associated with pathological gambling. Many are prone to relapse, if the related psychiatric problems are not treated. Finally, most gamblers will make several attempts before they make a permanent change in their behavior. When gamblers and their family members seek professional help, they can reduce the intensity and frequency of the symptoms associated with this problem.

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Developmental disabilities and insurance concerns

● *Don Van Dyke, MD; Mario Petersen, MD, MS; Deborah Lin-Dyken, MD; Virginia Miller*

There are 37 million Americans without health insurance and a large proportion are children.[1-3] Physicians who care for children, therefore, provide care for a significant proportion of the uninsured population.[3] The practice of denying health insurance for "high-risk" populations (including people with chronic medical conditions such as developmental disabilities) has resulted in often unaffordable health insurance premiums for these patients.[4,5]

Portability, or the ability to transfer health insurance from one employment position to another, is rare in the U.S. This means that health insurance coverage for children is often tied to parents' employment.[5] Parents of children with chronic illnesses or disabilities may feel trapped in jobs because of the need to preserve benefits for a chronically ill child.

Survey of 308 physicians

This study reports on a random mail survey of 308 physicians and 407 parents of individuals with developmental disabilities receiving care in a developmental disabilities program at the University of Iowa Hospitals and Clinics during the fiscal years 1986-1989. The study had two goals: (1) to determine health insurance concerns of parents of individuals with developmental disabilities; (2) to investigate physician perspectives on patients with developmental disabilities, including health insurance coverage, access to health care services and communication between parent and physician regarding health insurance issues. An effort was also made to determine which factors had the greatest influence in obtaining both health insurance and health care in this population.

The physician response rate was 67%. Of those, 95% were in private group practice with 55% family practitioners, 36% pediatricians and 9% other specialties. The parent response rate was 54%.

Keeping health costs down was a frequent concern voiced by many primary health care providers. While 38% of physicians felt that they succeeded in keeping health care costs down, another 31% felt they had little success in this endeavor. However, 63% of physicians admitted they never or rarely discuss with parents what medical services are covered by their health insurance.

Physicians who care for individuals with developmental disabilities see themselves as partners in managing health care costs, while 49% of parents said physicians are helpful in keeping cost down. While physicians were not satisfied with the compensation they received for providing care to patients with developmental disabilities, only 5% reported denying care to such patients. Almost two-thirds would see more Medicaid patients if compensation was better and 40% would see more individuals with developmental disabilities if there was better compensation.

These results are similar to those found by Minihan *et al*, in which 60% of physicians had concerns about accepting new Medicaid patients because of financial concerns; 91% felt financial compensation for Medicaid patients was inadequate.[6] In our study, over 20% of the physicians reported limiting the number of Medicaid patients.

Forced into Medicaid program

The health insurance system over time had a tendency to select out "high-risk" populations for denial. Often these families later obtained insurance through Medicaid. Factors increasing the chances of an individual having Medicaid include a history of denial of health insurance. Patients with cerebral palsy, men-

Don Van Dyke, MD
Mario Petersen, MD, MS
Deborah Lin-Dyken, MD
Virginia Miller
The authors are affiliated with the University of Iowa Hospitals and Clinics Division of Developmental Disabilities.

Developmental disabilities and insurance concerns

continued

tal retardation and spina bifida have an increased chance of being on Medicaid.

Only 3% of those had no health insurance. This is not surprising since most of these families included individuals with significant, ongoing medical needs. Those who were not able to afford private health insurance were able to get coverage through Medicaid. Almost 15% of parents reported limitations or inability to obtain health care because of the type of coverage offered them by their health insurance. While only 5% of parents reported an overt denial of care from a physician for their child with developmental disabilities, limitations of health insurance coverage possibly restricted their ability to obtain routine medical care or preventive care.[7] Recent studies by Stoddard *et al* demonstrate that children who lack health insurance are less likely to receive medical care than those children who have health insurance.[8,9]

Pre-existing conditions and lack of portability of health insurance are major concerns of parents of children with developmental disabilities. Forty-three percent of parents surveyed reported fears and concerns regarding loss of health insurance for their child because of change of job. Of these, almost 16% of the parents had their fears realized because of a job change. In addition, 27% of parents experienced difficulties in purchasing health insurance because of "pre-existing condition" limitations.

Parents with a high school degree or less who had Medicaid were the most satisfied with their health insurance. Parents with a college degree or more were fairly satisfied with their health insurance care coverage. Parents who were the least satisfied were those with health insurance coverage who had a technical degree or some college.

The survey also found a relatively high number of billings were written off, as physicians provide services to some individuals with developmental disabilities at their own cost. Discussing insurance issues with patients with developmental disabilities may improve satisfaction of parents and physicians.

References

References are available from the authors or the editors of *Iowa Medicine*.

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Just the facts

All political parties die at last of swallowing their own lies.

John Arbuthnot (1667-1735)
English physician and wit

Here we go again! The past four years have gone by with amazing speed. The promises of the last general election are in many instances unanswered. Now we hear new promises, as well as denials of past ones. It is no wonder that many voters have lost faith in their chosen parties, as well as the election process. True, the poor voter, because he has been hoodwinked by unfulfilled or empty promises, has had future hopes corrupted. Every four years we are bombarded by rhetoric that is nothing more than idle verbage (or is a better word "garbage"?).

Politics, I guess, has always been that way, here in the U.S. as well as in other counties. It seems sometimes the word "democratic" is taken completely out of context. By definition democratic pertains to encompassing or promoting the interests of the people. "Republican" pertains to or is characteristic of a group of people working freely and equally for the same cause. How ironic that at the recent Republican convention there was considerable dissension regarding certain causes. True, there may be varying opinions, but out-and-out bickering and demonstrations leave much to be desired.

We must admit that politics involves power playing, either by the politicians or their aids, or by representatives of the news media. The convention in San Diego was criticized by some of the media commentators as being void of much news. Within the ranks of the media was also much disagreement between purveyors of the written news and the electronic news. One factor that turns off the public is continual editorializing by news commentators. They seem to perceive the public as stupid dolts. Hence, more feeling of disgust by the citizens of our great country.

What is the answer to all this degradation of our society? A renewal of ethics is indicated. Moral decay surrounds us, from coasting through stop signs, dishonest promotion of consumer products to major crime. Some political leaders have lost their ethics of governing, as well as in their personal lives. Wouldn't it be great if we could again have a feeling of trust of those we elect to public office?

Voters can more easily decide on the issues if not given so much false rhetoric.

There must be a renewal of the ethics of virtue. Let each state his views without the negativism that has been so prevalent in recent years. Then, if they cannot back up their views at least be honest enough to admit their faults and attempt to make amends. Voters can more easily decide on the issues if not given so much false rhetoric. Let us not be dazzled by empty verbage. Impress us with facts; true facts. IM



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So live that when thy summons comes . . .

We—you and I—have lost a good friend. Dr. John Martin, a retired Chicago neurosurgeon who spent many years of his retirement in Clarinda, moved to Iowa City for his final five. Various reasons persuaded him to make that last move, but especially he was eager to make visits to his beloved collection of rare and historical books that he donated to the University of Iowa some 20 years before. Never married and with few relatives, he showered his attention, love and dollars on that magnificent book collection.

I said *you* lost a friend, too. You may puzzle at that, because you may not have known or even heard of Dr. Martin. But his friendship toward you was expressed through his generosity in making available to anyone in the world the opportunity to encounter, study, and be stimulated or awed by his treasure. The many first editions (e.g., Vesalius, Harvey, Morgagni, Jenner, Holmes, Darwin) and the superb atlases, herbals and texts, especially dealing with anatomy, neurosurgery, neurology and obstetrics, are precious jewels available to us all. His bequest of his remaining estate will continue to add gems to the collection. To examine manuscripts and books made hundreds of years ago and to reflect on the advances in knowledge and therapy that have become our legacy is to restore our faith in today's accomplishments and tomorrow's promises.

He showered his attention, love, and dollars on the magnificent book collection.

To visit an extraordinarily alert 91-year-old, dying of myeloma all too slowly to suit him, was not easy, but visits from his friends cheered him greatly. Near the end I took some poems written by a surgeon friend, the late Dr. George Bascom of Manhattan, Kansas, whose little-known writing I much admire. The poems were a solace to me and I thought they might be also to John. They were indeed. Because they might serve that purpose for you or some patient, I offer one of them here.



Richard Caplan, MD

Reassurance
Before I die
(I said to God)
I want to know,
Will lovers laugh
When I am gone
And children smile?
Will shadows still fall blue
On jeweled snow?
Will summer clouds
Catch glory as they sail,
Will leaves be lovely in the wind?
Will someone hear the holy birdcalls,
Love the wild snow,
The benediction of an evening fire
And gentle talk,
Moonrise,
Brilliant stars,
The wind—
"Oh, yes," God answered.
"All will be well."

If you would like more information about the collection in the John Martin Rare Book Room, or about the poetry of George Bascom, just contact me (319/335-6584 or fax 319/335-8515). IM

Classified Advertising

Mankato Clinic, Ltd.—A progressive group practice is seeking additional BE/BC physicians in the following specialties: acute/urgent care, family practice, oncology/hematology, orthopedic surgery and general internal medicine practice. The Mankato Clinic is a 70-doctor multispecialty group practice in south central Minnesota with a trade area population of +250,000. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information, call Roger Greenwald, Executive Vice President, at 507/389-8500 or Byron C. McGregor, Medical Director, at 507/389-8548 or write 1230 East Main Street, P.O. Box 8674, Mankato, Minnesota 56002-8674.

Keystone, Colorado—Ski condos, 3 minute walk to lifts, 2 bedroom, sleeps 4 to 6, amenities, very reasonable, from $850 per week. Call Dr. R. Bloch, 714/692-8025.

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Fort Dodge, Iowa—A busy otolaryngology practice is seeking locum coverage for weekends and some vacation time. Housing, transportation and malpractice provided. Send CV to Cindy Fellers, 800/360-4442; 804 Kenyon Road, Suite N, Physicians Office Building, Fort Dodge, Iowa 50501.

Washington, Iowa—Coastal Physician Services of the Midwest is seeking a BE/BC physician in primary medicine to be the medical director for the Emergency Department at Washington County Hospital. Must have 2 years emergency department experience. Guaranteed remuneration with benefits and malpractice insurance coverage. To learn more about this position, contact Ed Kennedy at 800/326-2782 or fax cover letter and CV to 314/291-5152.

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A rural hospital located 30 minutes from a Big 10 university is seeking a full-time ER physician to join 2 full-time ER physicians in expanding services. Must be BC/BE in family practice or other primary field. Certification in ACLS/ATLS/-PALS is required. Our candidate must also be interested in teaching, community involvement and be willing to make a commitment in a beautiful geographical area that offers year round recreation plus numerous opportunities for professional, educational, cultural growth and involvement. Excellent salary and benefit package with a financially strong and visionary 36-bed hospital with an expanding primary care and specialty medical staff. For confidential consideration, please send resume to *Iowa Medicine*, Box IM, 1001 Grand Avenue, West Des Moines, Iowa 50265.

Sioux Falls, South Dakota—Multispecialty group seeks family practitioner. Prefer OB interest, but will consider other including occupational medicine. Teach medical students and residents. Call 1:6 or better. Rated as *Money Magazine's* #1 city, great recreational and cultural opportunities, top notch schools and colleges. Contact Kathy Jordan, 1-800/546-0954, I.D. #4069IO, fax: 314/726-3009, e-mail: careers@cejka.com.

Advertising Rates and Data

Regular classified advertising sells for $2.00 per line with a $30 minimum per insertion. For members of the Iowa Medical Society the rate is $20 per insertion. Display classified advertising sells for $25 per column inch, per month. Sizes range from 1 column by 2 inches to 1 column by 6 inches. A variety of type sizes, borders, reverses or screens can be included in the ad. Blind box numbers are available upon request at no additional charge. Copy deadline is the 1st of the month preceding publication. Send or fax copy to *Iowa Medicine*, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

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Family Physician—Progressive group practice in Oskaloosa, Iowa is seeking an additional BC/BE family physician. Competitive salary and benefit package. Call schedule 1:9. Full time ER coverage. For additional information contact Linda Cohrt, Office Manager, Family Medical Center, PC, 1225 C Avenue East, Oskaloosa, Iowa 52577; 515/673-6762 or fax CV to 515/672-2258.

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fax 712/732-2538

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Des Moines 50315
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Cedar Rapids 52402
319/363-4622
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Fort Dodge 50501
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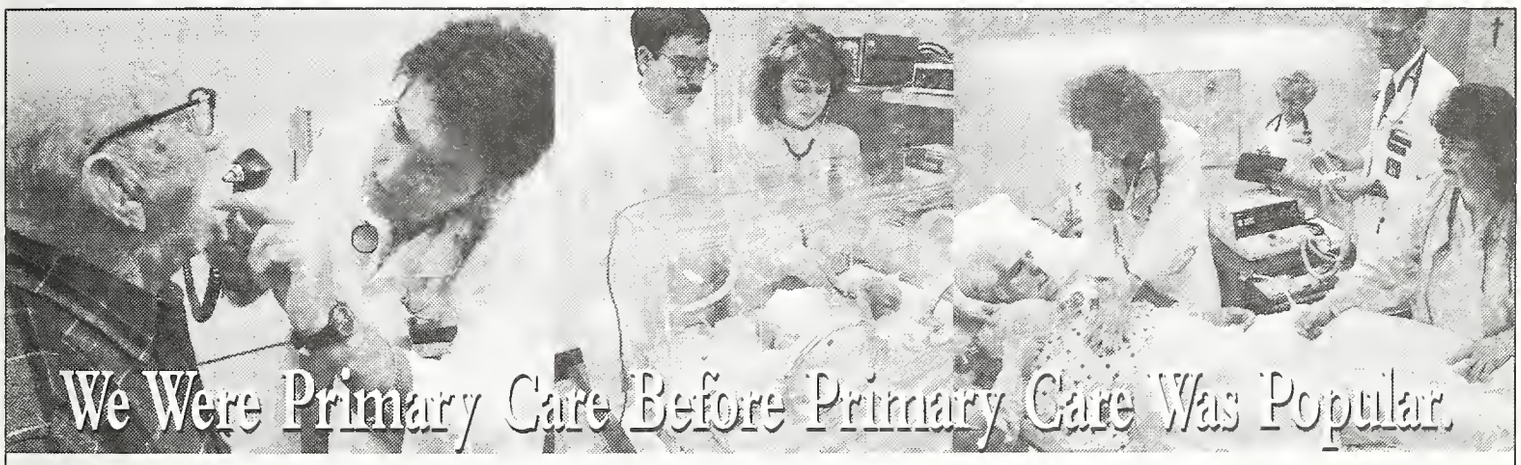
Urology

Fort Dodge Medical Center, PC
Steven P. Hoff, MD
800 Kenyon Road
Fort Dodge 50501
515/573-4141

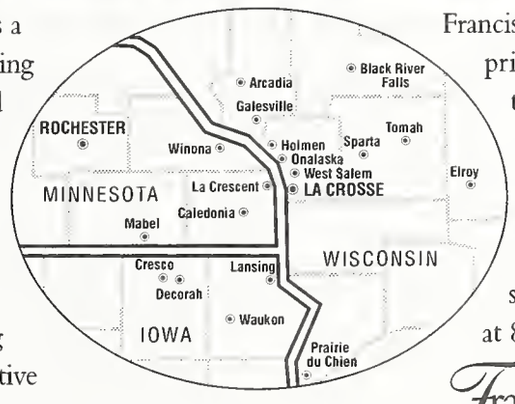
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The IMS Home Page

Watch for more information in the November–December issue of *Iowa Medicine*.



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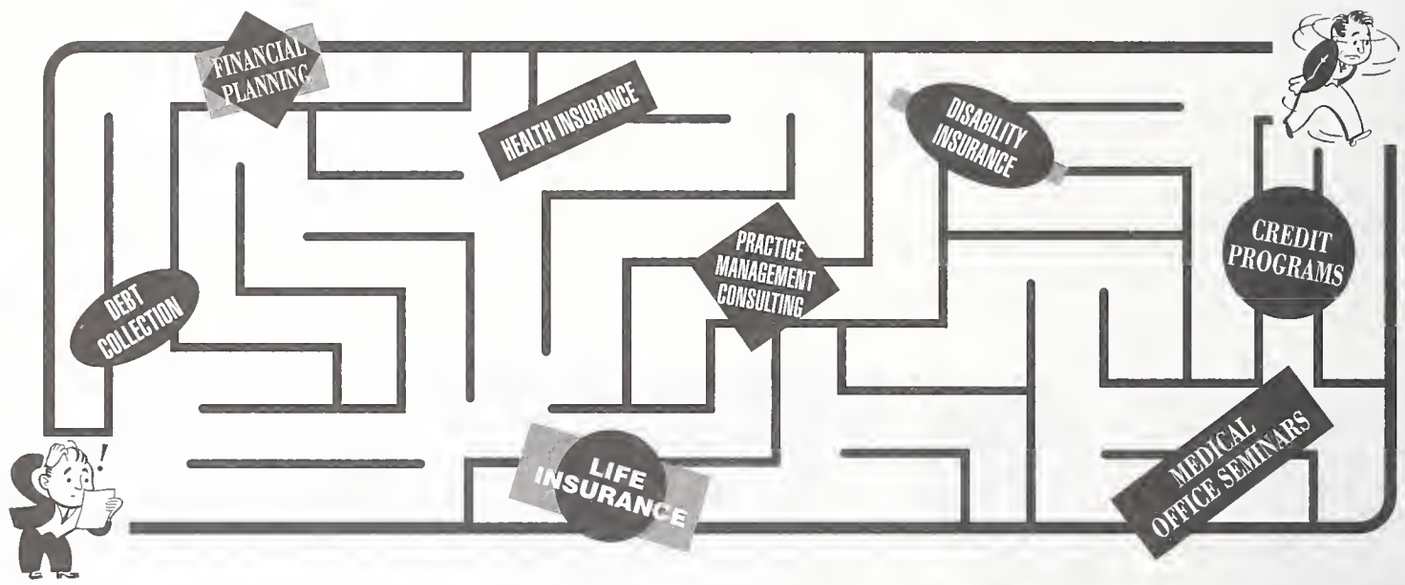


Franciscan Skemp Healthcare has a variety of primary care and other specialty opportunities available in *Wisconsin, Minnesota* and *Iowa*. The practices are available in ideal, family-oriented environments with outstanding recreational and cultural activities. Excellent public and private schools. Call Tim Skinner or Bonnie Nulf at 800/269-1986.

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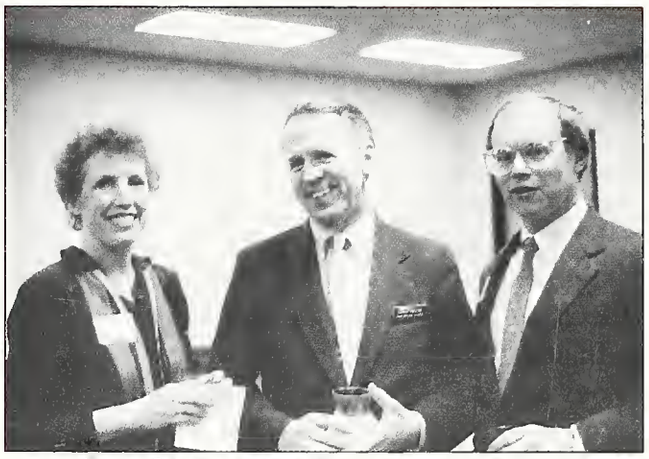
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Iowa Medicine

NAL OF THE IOWA MEDICAL SOCIETY | NOVEMBER–DECEMBER 1996

STACKS





STACKS

So long, Chief

Eldon Huston, retiring IMS executive vice president, reflects on his career and medicine in Iowa

page 362



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STACKS

Iowa Clinic's goal is statewide clinic system **(fifth in a series)** 349

Controversy over maternity care rules 352

BCBS reworks global OB policy 356

New IMS executive has strong legislative background 359

Strategic Health Care Systems

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- Selling Strategy

Occupational Health Program Development

- Needs Assessment
- Strategic Marketing
- Employer Education
- Medical Staff Alignment
- Strategic Planning
- Implementation
- Executive Seminars

Leadership Development

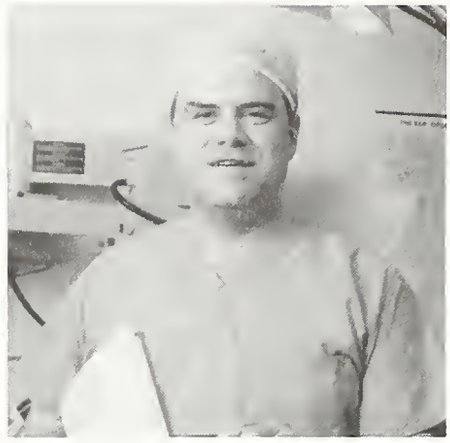
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"The Iowa Medical Society is the only organization which acts on behalf of all physicians and the medical profession. Our dual mission remains improving the practice environment for Iowa physicians and maintaining high quality care for their patients."



William McMillan, MD
President, Iowa Medical Society
Ottumwa otolaryngologist

say *yes!* to **IMS**

WHY? Because the IMS blocked an unprecedented attempt to codify clinical guidelines by stopping a bill in the 1996 Iowa Legislature which would have mandated group B strep testing for every pregnant woman.

say *yes!* to **IMS**

WHY? Because the IMS — through practice management seminars and individual consultation — offers advice on E & M coding issues and insurance payment policies which translate into thousands of dollars of billable revenue and risk management protection for Iowa practices.

say *yes!* to **IMS**

WHY? Because the IMS kept government from intruding further into your practice by helping shape proposals on maternity care to make sure the decision is left to patients and physicians.

say *yes!* to **IMS**

WHY? Because the IMS — through public health initiatives such as the campaign against domestic violence — helps your patients and garners positive publicity for Iowa physicians that money could never buy.

say *yes!* to **IMS**

WHY? Because the IMS stayed at the CHMIS table, taking every opportunity to point out potential problems for Iowa physicians and helping to delay implementation until a feasible plan can be devised.

say *yes!* to **IMS**

WHY? Because the IMS is working hard every day to advocate for Iowa physicians with third party payers, the governor's office, state and federal government and the courts.

say *yes!* to **IMS**

WHY? Because the IMS is the place Iowa physicians call with questions about PA rules, the BME, the Insurance Division, the Health Department and a host of other matters or when they need advice about laws, administrative rules and legal issues.

IMS

Working for Iowa physicians and their patients

Look on the other side for a special message about the Iowa Medical PAC and the IMS Education Fund!

IMS Education Fund



The IMS Education Fund (IMSEF) is a charitable, educational and scientific arm of the Iowa Medical Society. It is funded in part by contributions from physicians through a $50 entry on the IMS dues statement.

Your contribution to the Fund supports the medical student loan program and other health education and public service projects which benefit the public and improve the image of physicians. The IMS domestic violence project is one example of a recent program designed to help Iowa health care professionals recognize and care for their battered patients.

Beginning in 1996, the IMSEF Fund-raising Committee instituted a "give back to your profession" fund drive to replenish those areas most in need of funds. One such area is the George H. Scanlon Medical Student Loan Fund. Since inception of the loan program, 858 loans have been made to Iowans, totaling $3 million. Because repayment does not begin for three years after graduation, the amount of repayment income from prior loan recipients is not sufficient to meet the needs of current eligible medical students.

The Walter L. Bierring Donor Society was created in 1996 to recognize physicians who contribute to the IMSEF, with the following categories:

Life Member	$5000 (5-year payment option)
President's Circle	$1000 (5-year payment option)
Trustees' Circle	$500-999 (5-year payment option)
Patron	$100-499
Contributor	$50-99
Other	$1-49

Please consider giving back to your profession through the IMSEF today. Send your gift to the IMS Education Fund, 1001 Grand Avenue, West Des Moines, Iowa 50265 or call 515/223-1401 or 800/747-3070 for more information.

Iowa Medical Political Action Committee

IMPAC—the political arm of the IMS—is a voluntary organization of physicians, spouses and other friends of medicine. IMPAC is an organized way for physicians to participate in the political process. Contributions to IMPAC are shared with AMPAC, the AMA's political action committee, which supports candidates for the U.S. Senate and House of Representatives. IMPAC supports candidates for the Iowa Legislature and other state offices; AMPAC supports congressional candidates.

IMPAC's Board—14 physicians and two IMS Alliance members—supports quality candidates based on philosophy on medical issues and local physicians' recommendations.

IMPAC is funded by contributions. You may contribute to IMPAC through your dues statement. A $100 contribution will give you a sustaining membership and $250 a gold club membership. Please contribute to IMPAC by personal check. State and federal laws prohibit use of corporate funds.

IMPAC
IOWA MEDICAL POLITICAL ACTION COMMITTEE

Neither the American Medical Association nor the Iowa Medical Society will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Voluntary political contributions may be used in connection with federal elections and are subject to the prohibitions and limitations of the Federal Election Campaign Act. (Federal regulations

IMS *DEADLINE* news November-December, 1996

Late-breaking news of interest to Iowa physicians

●**CONTINUING EDUCATION CREDITS** have been obtained for the IMS program "When Bad Things Happen to Good People – Why You need a Billing Compliance Program" (see insert in this issue). Following is a listing of the organizations and credits:

CATEGORY 1, AMA – This program is jointly sponsored by Iowa Methodist Medical Center, which is accredited by the Iowa Medical Society to sponsor continuing medical education for physicians. Iowa Methodist Medical Center designates this CME offering for 3.00 credit hours in Category I of the AMA Physician's Recognition Award.

AAFP – This program has been reviewed and is acceptable for up to 3.0 prescribed credit hours by the American Academy of Family Physicians (AAFP). AAFP prescribed credit is equivalent to AMA PRA Category I credit for the AMA Physician's Recognition Award. When applying for the AMA PRA, prescribed hours earned must be reported as prescribed hours, not as Category I.

IOMA – This program has been approved by the American Osteopathic Association (AOA) for 3 credit hours of Category 2B.

RN – This program has been approved for nursing continuing education for 0.30 CEUs by the Iowa Nurses Association, Provider #25.

ACMPE – This program may qualify for continuing education credit in the American College of Medical Practice Executives (ACMPE). To apply for ACMPE credit, you may submit a generic ACMPE credit-hour form, along with a copy of the program agenda.

●**AT THE REQUEST OF THE US DEPARTMENT OF HUMAN SERVICES,** the U of I College of Medicine has hired an independent accounting firm to review its Medicare billing procedures and could owe the government millions of dollars before the audit is over. A similar Medicare audit at the University of Pennsylvania cost that school $30 million. The federal government intends to audit the Medicare billing practices of all 125 medical schools in the US. University Hospitals is not involved in the audits.

●**AS OF PRESS TIME,** Rep. Greg Ganske was leading his opponent Connie McBurney by a 16 point margin. Ten days before the election, Ganske garnered an endorsement from the *Des Moines Register* and had a 52% majority "despite the million dollar onslaught of television advertising by special interests", commented Rep. Ganske in a campaign press release.

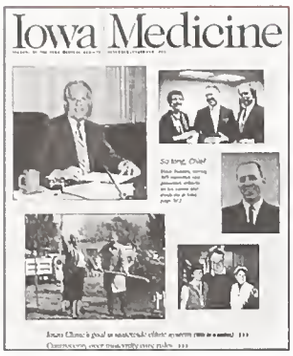
●**IF YOU'RE INVOLVED IN A FREE CLINIC IN IOWA,** IMS staff would like to hear from you. IMS leadership is investigating ways to assist physicians who want to start free clinics. Please call Becky Roorda at the IMS.

●**THE IMS WEB SITE** is up and running; however, some portions of the web site are still under construction. The IMS web site address is http://www.IowaMedicalSociety.org. See the enclosed insert for details on the IMS site and the Internet in general. In order to access certain sections of the IMS web site, you will need a password. IMS member physicians may call Melanie Finke or Laura Nelson at the IMS to get a permanent password.

●**IMS STAFF IS WORKING ON A NEW VERSION** of the *Physician's Guide to Iowa Law and Medical Records*. The new guide will be mailed to all IMS members in December. It will also contain administrative rules relating to the Board of Medical Examiners and physician assistants.

For more information about any *DEADLINE* news item, call Chris McMahon at IMS headquarters, 515/223-1401 or 800/747-3070.

Iowa Medicine



About the Cover

This month's cover is dedicated to retiring IMS Executive Vice President Eldon Huston.

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EDITORIAL

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This month, the office of the IMS executive vice president will change hands for the first time in 22 years. Leading the IMS into an uncertain future will be a challenge for IMS physicians and staff.
● *THE PRESIDENT COMMENTS*

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Michael Abrams, director of government relations and marketing for the Indiana State Medical Association, is the new IMS executive vice president.

362 **Huston reflects on medicine in Iowa, long career with IMS**

On the eve of his December retirement as IMS executive vice president, Eldon Huston reflects on his career and his philosophy of leadership. ● *ELDON HUSTON*

SCIENCE AND EDUCATION

367 **Microsurgical epididymal sperm aspiration**

The authors discuss this relatively new technique to fertilize eggs, thus enabling couples to conceive biological children. ● *JAY SANDLOW, MD; JAMES DONOVAN, MD; AMY SPARKS, PHD; CRAIG SYROP, MD; BRAD VAN VOORHIS, MD; DALE STOVALL, MD*

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AL HOLT'S RECOVERY CAN BE MEASURED IN YARDS.

Including his own back yard. Because just two weeks after suffering a heart attack, Al was back home cutting his grass — thanks to HealthEast St. Joseph's Hospital and the Links to Recovery program.

It all started when Al was rushed to HealthEast St. Joseph's Hospital with severe chest pain. There, he underwent a cardiac catheterization which confirmed a coronary artery blockage. The next day, cardiovascular surgeons performed a progressive new bypass procedure on Al called MID-CAB which is done while the heart continues to beat.

So there is no need for heart-lung bypass, and the incision can be smaller. As a result, there's less postoperative pain and recovery is faster. In fact, three days later, Al was discharged home where he is undergoing the final link to recovery — an extensive outpatient cardiac rehabilitation program.

Thanks to our Links to Recovery program — which also includes HealthEast Bethesda Lutheran Hospital and Rehabilitation Center, and 15 primary care clinics — Al found state-of-the-art care in his own back yard.
Visit us on the Web at: http://www.healtheast.org

For More Information
Call 1-800-566-2720

Links to Recovery

HealthEast St. Joseph's Hospital
69 W. Exchange Street, St. Paul, MN 55102

HealthEast Bethesda Lutheran Hospital
& Rehabilitation Center
559 Capitol Boulevard, St. Paul, MN 55103

Reflections on leadership

Change is always tough to manage, especially when it is the manager who will change. For 22 years Eldon Huston has managed change for the Iowa Medical Society. Using his abilities for great advantage locally, on a statewide basis and nationally. He was there for the birth of the IFMC and creation of IPMIT (now part of MMIC). He helped us deal with the malpractice crisis and the creation of Medicare. He has helped mix town and gown and stood fast against those who would oppose the ethical and responsible practice of medicine. He watched while inpatient payments and Hill-Burton built hospitals and later saw DRGs, capitation and managed care whittle them down. All of this was done with a new president, vice president and trustee each year. It seems the only constant was that things were going to change.

Did the blessing of Eldon just happen? No. Eldon's leadership was the result of being passionately involved in the constant evolution of medical practice and health care delivery. Meeting all the change our society could throw at the system and still maintaining the ethics, dignity and value of being a physician. A tough act to follow.

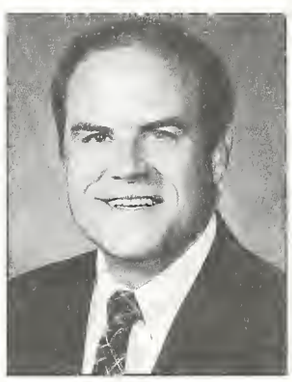
Can we be the same effective, caring conscientious IMS under new leadership? My answer is a resounding "yes", because the second part of our good leadership is the IMS itself. Leading physicians has been compared to herding cats, but we have been led and have accomplished much. I believe we all are united by our common goals and a set of core ideologies that are the underlying foundation for medical practice and for the organizations representing physicians. Inside ourselves and inside our profession, we find the ideology and shared vision which will be authentic and unshakable. By looking inside ourselves we find the values which will sustain our profession, help us stay the course and keep our heads and our heading, while those about us are losing theirs.

We may disagree within the family of medicine but when we face the world outside we must present a united front.

I believe we all are united by our common goals and a set of core ideologies.

In an interview for *Iowa Medicine* (see page 362), Eldon Huston said "The mission of the IMS should continue to be to promote the science and art of medicine and the betterment of public health. The IMS is the voice for Iowa physicians."

So as Michael Abrams begins his journey as executive vice president of the Iowa Medical Society, armed with the skills of a new age and the ability to articulate our common ideologies, find the right political answers and lead the IMS staff through the strategic planning process, it is our job to follow that core ideology. Our leaders must lead the way, holding the light of knowledge, exposing pitfalls, clearing the path toward progress in the prudent pursuit of change. IM



William McMillan, MD

MANAGED CARE

news you can use

Iowa Health System forms partnership to serve rural Iowans

Iowa Health System, which operates Integra Health and hospitals in Des Moines, Sioux City, Waterloo and Cedar Rapids, has announced that it will join with Lutheran Health Systems (LHS) of Fargo, North Dakota to form a new integrated delivery system. The new system will serve rural Iowans. LHS has hospitals, nursing homes, clinics and an extensive home care service in 17 states.

Health outcomes worse for elderly, poor in managed care

Elderly and poor people who are chronically ill tend to have worse health outcomes when treated in health maintenance organizations rather than in fee-for-service systems, according to an article in the October 2 *JAMA*. The authors of the article studied 2,235 patients in Boston, Chicago and Los Angeles from 1986-1990. The patients, aged 18-97 years, suffered from chronic illnesses. Those treated in an HMO were twice as likely to decline in health than those treated in an FFS.

Physicians can sue administrators of employee benefit plans

In a recent unanimous decision by the Michigan Court of Appeals, physicians established the right to sue administrators of employee benefit plans for breach of physician participation agreements, notwithstanding federal ERISA preemption laws. The decision is based on a 1994 case involving a group of health care providers who sued Blue Cross Blue Shield of Michigan for violating state law in denying them the opportunity to take part in the program, Premier Plus. The Michigan State Medical Society cites this as a success in its efforts to restrict broad interpretation of ERISA preemption on Michigan laws relating to health benefits.

Geneseo physician group aligns with Genesis

Family Medical Associates, Ltd., a group of six family practitioners in Geneseo, Illinois, has joined the Genesis Health System. Genesis Medical Group is comprised of 20 primary care and specialty physicians affiliated with Genesis Health System. By joining Genesis, Family Medical Associates becomes the first Genesis Medical Group physician office facility in Henry County. Stephen Sidwell, MD, vice president of medical services development for Genesis, said the affiliation "further demonstrates our commitment to serving the Iowa-Illinois area."

Charges dismissed against Florida HMO medical director

The state of Florida has dropped criminal charges of practicing medicine without a license which it brought against an HMO director. The state had alleged that a board-certified physician, licensed in two states, was practicing medicine when he made utilization review decisions for the HMO. The state failed to make its case.

The Iowa Clinic's goal is statewide clinic system

(Fifth in a series)

The Iowa Clinic, PC began as an IPA formed in 1993 by 12 groups of 40 physicians. It made the transition into a clinic without walls (100 physicians) in 1994. One year later, it merged into a professional corporation.

No organization, no clout

The organization is comprised of 22 practices, 80-plus physicians and 300-plus employees. It offers 15 areas of multispecialty care.

"This started because a group of physicians perceived that by not being organized, we had little clout with the groups we needed to influence," explains Dr. David Boarini, chairman of the clinic board of directors.

"In 1989, some of the physicians attempted to form a similar organization which failed. In 1993, a group of us got together and decided that our initial attempts were a good idea. Several of us — on our own time and at our own expense — hired a consultant and got an IPA organized."

PHO 'too loose knit'

The group avoided the PHO model, says Dr. Boarini, because "legally, it is too loose knit to answer doctors' needs. A PHO can only accomplish one or two purposes."

Today, after several major transformations in a relatively short time, the Iowa Clinic, PC is a fully-integrated, multispecialty organization.

"We're a wholly-owned professional corporation with executive management," Dr. Boarini explains. "Physicians own it and govern it."

Dr. Boarini explains that all the stockholders in the company are physicians and that the officers hold unpaid positions.

"Physicians are entirely responsible for the company, but we have very little involvement with the day-to-day operations in order to focus on the practice of medicine," Dr. Boarini explains. "We have professional staff who handle the administrative functions."

The Iowa Clinic's structure — a professional corporation — has four advantages, according to clinic administrators:

- It provides for collective contracting and the ability to manage risk.
- It supports the formation of a modern information system partnership.
- It gives the clinic access to volume cost saving opportunities.
- It is part of a health system strategy.

Goals for the future

In April of this year, the Iowa Clinic, PC formed a joint venture medical services organization, Physician Management Resources, LC., with the Iowa Health System.

Physician Management Resources currently has 20 physicians, nine locations and 100 employees.

The joint venture enables both organizations to offer a full range of options for physicians to consider. These include practice purchase, practice merger, or selective service contracting.

"In order for physicians to be financially successful, we feel they will need these types of services in order to influence outcomes and better manage the business of health care," Dr. Boarini concludes.

The future goal of the Iowa Clinic is summed up this way in written materials from Physician Management Resources:

"To form a statewide multispecialty clinic system that is recognized for the quality care and cost-effective medicine provided by its physicians." IM

"Several of us, on our own time and at our own expense, hired a consultant and got an IPA organized."

KEY CONTACTS:

Iowa Clinic, PC
515/241-5785

David Boarini, MD
Chairman and President

Ed Brown
Chief executive officer

Kevin Cunningham, MD
Medical director

If you know of other innovative practice arrangements — especially those controlled by physicians and positioned to compete in the managed care market — call Barb Cannon or Chris McMahon at the IMS, 515/223-1401 or 800/747-3070.

IMS Update

IMS offices up for election in 1997

Offices up for election at the Iowa Medical Society's Annual Meeting April 18-20 include: (The length of each term is in parenthesis, along with the name of the physician now holding the office.)

PRESIDENT-ELECT (1) — Harold Miller, MD
VICE-PRESIDENT (1) — Hunter Fuerste, MD
TRUSTEE (3) — John Brinkman, MD
HOUSE SPEAKER (1) — Donald Kahle, MD
VICE SPEAKER (1) — Tom Throckmorton, MD
AMA DELEGATES (2) — Clarkson Kelly, Jr., MD; Daniel Youngblade, MD
AMA ALTERNATES (2) — Bernard Fallon, MD; Bryan Pechous, MD

Judicial Councilors are elected by a district wide vote of eligible IMS voting members. The names of physicians elected as Judicial Councilors will be submitted for confirmation by the 1997 House of Delegates. Details will be sent to county medical societies due to elect councilors in 1997.

Council seats up for election are:

DISTRICT 3 — Eugene Kerns, MD
DISTRICT 7 — Steven Erickson, MD
DISTRICT 8 — Leo Milleman, MD
DISTRICT 12 — John Fernandez, MD
DISTRICT 15 — Kathryn Opheim, MD

The IMS Program Committee is making plans for the 1997 Scientific Session, which

MARK YOUR CALENDARS

Mark your calendars now for the 1997 IMS House of Delegates and Scientific Session

Friday – Sunday, April 18 – 20
Embassy Suites • Des Moines

AT A GLANCE

The University of Iowa is one of six American universities leading a national effort to curb binge drinking on and off campus. The UI will receive a one-year developmental grant of $60,000 and will be eligible for a planning and implementation grant. The grant funds will be used to create model approaches for reducing high-risk drinking on campus.

IMS dues statements went out in mid-October. Iowa is unified at the state and county levels. Prompt payment of your dues will be greatly appreciated.

What is the IMS doing for Iowa physicians? Don't miss the special insert in this month's Iowa Medicine *highlighting just a few of the accomplishments of the Iowa Medical Society on behalf of Iowa physicians.*

NEWS FROM IOWA MEDICAL GROUP MANAGEMENT ASSOCIATION (IMGMA)

Looking for answers?

IMGMA has grown from under 20 members in 1978 to over 600 in 1996. Our membership is comprised of managers from one-physician offices to large clinic groups.

New members are very important to IMGMA. The IMGMA Membership Committee greets each new member personally through the new member breakfast held during each IMGMA conference.

Being active in IMGMA gives members access to information about the latest developments in their profession. IMGMA programming is accredited for CEU and designed with member interests and concerns in mind. The opportunity to network with peers is a big asset in the ever-changing world of health care delivery.

Our officers and committees working together have made IMGMA strong. Because of the size of our association, we have been able to approach and work with insurance carriers on reimbursement; our legislative committee has provided insight into future needs.

IMGMA cares about our members regardless of whether they work for one physician or many. Member ideas and needs are why 600 people have joined IMGMA. Together, we can lead the physician office into the twenty-first century. To join IMGMA, call Dana Petrowsky at the Iowa Medical Society at 515/223-1401 or 800/747-3070 or ask a member of the IMGMA Membership Committee.

(This article was written by Judy Cardenas of HealthMed, Inc. in West Des Moines, a member of Iowa Medical Group Management Association.)

On November 11, Mike Abrams will join the IMS staff as the new executive vice president. Turn to page 359 for more information about Mr. Abrams. An interview with Eldon Huston, the retiring IMS executive vice president, begins on page 362.

IMS offices up for election in 1997

Offices up for election at the Iowa Medical Society's Annual Meeting April 18-20 include: (The length of each term is in parenthesis, along with the name of the physician now holding the office.)

PRESIDENT-ELECT (1) — Harold Miller, MD
VICE-PRESIDENT (1) — Hunter Fuerste, MD
TRUSTEE (3) — John Brinkman, MD
HOUSE SPEAKER (1) — Donald Kahle, MD
VICE SPEAKER (1) — Tom Throckmorton, MD
AMA DELEGATES (2) — Clarkson Kelly, Jr., MD;

Specialty society update

The Iowa Medical Group Management Association held its fall meeting in Davenport September 18-20. The meeting focused on how to deal with the new managed care environment. New officers are: Steve Hilpipre, president; Denise Chaffee, president-elect; Nephtali Matta, treasurer; Julie Barto, secretary. New Board members are: Sue Hopkins, Des Moines; Robert Mason, Mason City; Jeanette Sargent, Carroll.

The Iowa Psychiatric Society held its annual fall meeting in Cedar Rapids September 20-21. Richard R. Preston, MD Awards for Service were given to State Representative Betty Grundberg and Alliance for Mentally Ill President Claudine Harris. John Gambill, MD was recognized for his long service to the IPS.

The Iowa Association of County Medical Examiners will hold its education and business meeting November 8 at the Hotel Fort Des Moines. Dr. Mark Gold, nationally recognized expert on drug abuse, will be keynote speaker.

The Iowa Academy of Otolaryngology Board of Directors will hold a membership meeting Friday, December 6 at the University of Iowa following the Grand Rounds Conference at 4 p.m.

For more information, contact Dana Petrowsky or Dave Furneaux at 515/223-2816 or 800/728-5398.

Focus on IMS Alliance

Consider these facts:

- Over 10% of Iowa births are to teens.
- 80% of teen births are out of wedlock.
- The total cost to society of adolescent childbearing is estimated to cost $9 billion per year.
- Teen mothers are 50% more likely to deliver low birth weight babies.
- Low birth weight babies are 3 times more likely to experience neurological problems and other preventable handicapping conditions.

Consider these solutions:

- Call 800/747-3070 to acquaint yourself with the Iowa Medical Society Alliance.
- Mail your $55 dues contribution to the IMSA to help finance health and safety programs.
- Mail your check for $250 to IMSA to purchase a "Baby Think It Over" doll to be used for parenting instruction in the school of your choice. Our goal is to distribute 1000 dolls across Iowa; to date 195 dolls have been purchased.

We need everyone's help to reach this goal. Call Karen Messamer at 515/673-3751 for more information.

Iowa physician on AMA committee

Clarence Denser, Jr., MD, a member of the IMS delegation to the AMA, has been asked to chair the Reference Committee on Amendments and Bylaws at the AMA's Interim Meeting December 8-11. IM

Legislative Affairs

AT A GLANCE

More than 125 physicians and physician spouses are seeking elected office this year, including 29 running for Congress. This is double the number last year, according to an informal poll of state medical societies. In Texas, six physicians are vying for seats in the House of Representatives.

led the managed care revolution, may also be on the cutting edge of a consumer backlash, if voter initiatives in two states are any indication. Two California referendums seek patient and provider protections; one in Oregon would ban capitation.

Parental notification of abortion

Legislation was passed in 1996 requiring parental notification prior to performing an abortion on a minor. This was a very controversial issue. The compromise legislation that resulted from the controversy contains provisions that will affect all physicians who provide care to pregnant minors.

The law provides that upon the initial visit to a physician, a pregnant minor must be offered a video which explains the options available.

The physician must keep a record that the minor was offered the video. A video is being developed through the Iowa Department of Public Health which will be available for use by physicians and others providing care to pregnant minors.

Proposed rules to implement this new law have been published for comment. The IMS will provide extensive comments to try to make the process more practical and less onerous for physicians while still maintaining the intent of the law.

Call Becky Roorda at the IMS for more information or a copy of the proposed rules.

Maternity care

Controversy has erupted over the rules proposed to implement HF 2369, relating to coverage by third party payers of maternity care.

There is disagreement over the interpretation of the proposed rules, a disagreement which is focused on the following two issues:

- Whether it is necessary to specify in the rules that coverage must be provided for a minimum of 48 hours for a normal delivery;
- Or, whether it is sufficient to refer to the Guidelines for Perinatal Care established by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

Both the statute and the proposed rules say that coverage must be provided for the length of hospital stay determined to be medically appropriate by the physician for the mother and the baby after consultation with the mother in accordance with these guidelines.

The statute and the proposed rules also prohibit third party payers from deselecting or taking other punitive measures against physicians who follow the statute and the guidelines. The IMS supports these provisions.

Pediatricians have voiced concern that the proposed rules do not provide the same protections as the statute. It is expected that changes will be made so that the language of the proposed rules is identical to the statute.

Before it recessed, the U.S. Congress agreed to legislation which will prohibit drive-through deliveries.

Under the new law, the decision as to how long a mother and her newborn will remain in the hospital will be made by the mother and her physician.

Passage of this federal measure will not affect implementation of the Iowa law.

The AMA hails laws banning drive-through deliveries as "a strong first step toward assuring that cost containment will not be the primary or sole consideration in determining how and which health care services will be paid for in the new era of managed care".

Call Becky Roorda at the IMS for more information or an update.

Committee on Legislation

The IMS Committee on Legislation is meeting November 12 to finalize recommended priorities for the 1997 legislative session. Watch for details in the January issue of *Iowa Medicine*.

Anti-gag clause legislation

Legislation to ban gag clauses was not enacted by Congress before it recessed, but will be introduced again early next year, says the AMA. The legislation will make it unlawful for any health plan to restrict medical communications between physicians and patients and prohibit health plans from taking adverse action against physicians on the basis of a medical communication to a patient.

Legislation to ban gag clauses in physician managed care contracts saw a great deal of discussion and debate during the 104th Congress, due mostly to the efforts of Iowa Congressman Greg Ganske, says an AMA legislative bulletin.

Supreme Court to rule on assisted suicide

The U.S. Supreme Court has decided to deliberate on whether or not physician-assisted suicide is a constitutional right. Responding to the Court's announcement, Dr. Nancy Dickey of the AMA Board of Trustees said the AMA is "extremely pleased" that the Court will judge the constitutionality of this "misguided and unethical practice".

Dr. Dickey was interviewed on CNN's Crossfire and on CBS Radio Network regarding the AMA's opposition to physician-assisted suicide.

More info on fraud and abuse provisions

In an attempt to address physician concerns about fraud and abuse provisions contained in the Kennedy-Kassebaum health care bill, the AMA has published excerpted information on key provisions in the law. In addition, the AMA has compiled a chronology of their activities related to fraud and abuse.

For copies of these documents, call Paul Bishop or Cheryl Peers at the IMS. IM

IMS HEADQUARTERS

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GENESIS HEALTH SYSTEM

Genesis Pain Management Center, Bettendorf, Iowa

Medical Economics

AT A GLANCE

Dr. Nancy Dickey was interviewed recently on CBS Evening News, defending physicians against proseeutors who seek to hold physicians criminally liable for medical mistakes or errors in judgment. Dr. Dickey told CBS that the trend toward criminalization of medical decision-making could have a chilling effect on physicians' willingness to accept high risk cases.

A group of investors in the world's largest pension fund participated in a news conference urging the nation's teachers to divest more than $1.5 million in tobacco investments. The investments are held by the Teachers Insurance and Annuity Association's College Retirement Equities Fund, the largest of all institutional investors in Philip Morris.

Alert on OIG lab audits in Iowa

The IMS has become aware that the Office of the Inspector General (OIG) in Baltimore sent approximately 225 "surveys" to physician-owned laboratories (office labs) asking about documentation of specific requests for certain blood tests. About 15 surveys went to Iowa physicians. The survey had to be completed and returned within 10 days or penalties apply.

The survey had to be correctly answered, but might reveal problems with the way lab work is ordered in a physician's lab.

Four IMS member physicians have contacted the IMS regarding these OIG audits and were referred for legal counsel.

With the increased audit activity from OIG, Iowa's Medicare carrier and others, IMS members are advised to carefully review their own insurance and billing procedures and the adequacy of their medical records documentation. In addition, it is wise to seek legal counsel early in the audit process to ensure the situation is handled appropriately.

AMA convinces HCFA to rescind policy

The AMA has convinced HCFA to rescind a policy that was scheduled to go into effect October 1. The policy would have further reduced payments for newly-approved waived testing methodologies under CLIA.

The Administration had instructed carriers to begin using "gap-filling" payment methodologies on October 1 for state-of-the-art waived lab testing methodologies which could have resulted in lower lab payments than existing waived lab tests.

Shorter hosptial stays not just for OB

Shorter hospital stays for new mothers and infants may be generating lots of attention, but other medical diagnoses have resulted in even sharper drops in the average hospital visit, says the AMA. Advancements in medical technologies have moved many procedures to outpatient settings.

From 1969 to 1993, the average length of hospital stay has declined 54% for mononucleosis; 61% for acute myocardial infarction; 64% for otosclerosis; 78% for cataract; and 81% for detachment of retina.

HCFA cancels practice expense survey

Medicare officials have canceled an ill-fated survey they once said was critical to their congressionally mandated effort to revamp the practice cost portion of the program's physician payment scheme.

The decision was based on the poor response HCFA received from its phase one survey collection, which targeted 1,500 physicians. The AMA believes the poor response was due to the time-consuming nature of the survey.

Despite this setback, HCFA says that the date for implementing a final rule on practice expense remains January 1998. However, without this data, it may be difficult for HCFA to meet this deadline.

The AMA supports a delay in implementing the new practice expense charges. Also, a coalition of procedure-oriented specialists, who face cuts of up to 30%, says more time is needed to develop the necessary data to ensure accurate results. IM

"When Bad Things Happen to Good People"

A special Iowa Medical Society seminar on fraud & abuse and compliance programs will be broadcast over the Iowa Communications Network to 25 locations around Iowa. See enclosed insert for details!

DATA & TECHNOLOGY

Less-publicized requirements of Kennedy–Kassebaum law similar to Iowa CHMIS

In August, Congress passed the Kennedy-Kassebaum bill, officially titled the Health Insurance Portability and Accountability Act of 1996. While it is best known for making health insurance more portable and experimenting with medical savings accounts (MSAs), several other provisions are of importance to physicians.

Standards for electronic interchange

The law promotes the establishment of standards for the electronic data interchange (EDI) of a variety of health care transactions. Within 18 months, the secretary of the Department of Health and Human Services (HHS) must establish standards for the following transactions: claims, claim status, eligibility, payment and remittance advice, enrollment/disenrollment, premium payment, first report of injury and referrals. The department has 30 months to establish standards for attachments to claims.

A unique identifier for providers, patients, plans and employers must be adopted by HHS. It is unclear at this time how these will be developed, but a single identifier for providers and patients will facilitate the sharing of data between physicians, other providers and health plans.

Concerns over confidentiality

The bill also raises concerns about confidentiality. The bill does set fines and imprisonment for anyone who violates the confidentiality of an individual's medical record, but many patient advocacy groups feel the measures are insufficient.

In addition, HHS and the Department of Commerce must set standards for the electronic transmission and authentication of signatures. This will streamline the processing of information and reduce the need to maintain paper records for legal, accreditation or regulatory purposes.

Whenever possible, HHS must adopt standards already developed by standard-setting organizations accredited by the American National Standards Institute (ANSI). If standards do not exist, HHS may adopt non-ANSI standards, but only after consulting with leading standard-setting groups, such as the National Uniform Claim Committee, which is chaired by the AMA.

Physicians will not be required to send transactions electronically. However, providers who choose to operate electronically will have 24 months to comply with the new standards.

Physicians who do not want to alter their computer systems to HHS standards will be allowed to contract with clearinghouses that have an ability to convert non-standard EDI formats into adopted standards.

The standard-setting should allow much easier transfer of electronic health care data, which in turn will produce huge cost savings over time. Standards also pave the way for simplified computer-based patient records, opening the possibility for a cradle-to-grave medical record on each and every American.

Similarity to Iowa CHMIS

Iowa physicians will recognize the similarities in Kennedy-Kassebaum with the Iowa CHMIS. While CHMIS is undergoing a transformation, it appears one of its important objectives will be the creation of standards for electronic health transactions to be embraced by providers and payers operating in Iowa. IM

For more information, call Ed Whitver, IMS manager of health care data and technology, 515/223-1401 or 800/747-3070.

Practice Management

BCBS reworks global OB policy

The IMS is pleased that Blue Cross Blue Shield of Iowa has reconsidered its proposed global OB policy.

Based on concerns raised by the Iowa Medical Society and others immediately after the policy change was announced, BCBS agreed to delay any change until the policy could be discussed further.

IMS physicians have been asked to help BCBS revamp the proposed policy. Family physicians and obstetricians are scheduled to receive notice of the change directly from BCBS sometime this month.

The policy will follow the ACOG definition of a "global OB package", which includes prenatal physician visits, prenatal urinalysis and the delivery. Other medically necessary predelivery laboratory and diagnostic tests will be paid "outside" the global package payment.

In addition, documentation of complex conditions or comorbidities may justify payment for additional visits "outside" the global package payment.

Payment for the global package will not be changed at this time, but will be analyzed for future changes.

MBC contract extended by IDHS

The state's contract with Merit Behavioral Care of Iowa (MBCI), the company which manages mental health services provided to Iowa's Medicaid patients, has been extended through February, 1998.

Chuck Palmer, director of the Iowa Department of Human Service (IDHS), made the decision based on a recommendation of the Council on Human Services.

Palmer also directed the Mental Health Access Plan subcommittee to begin work on an RFP for the new contract period, which will begin March 1, 1998.

In June, the Council accepted the subcommittee's initial report which called for extending the contract through July of 1997 as well as monitoring MBCI's compliance with performance indicators.

The IDHS believes that initiating the contract reprocurement process now will ensure there is ample time for training and orienting everyone affected by any changes the new contract may bring.

The subcommittee also recommends that, as part of the next contract, the IDHS make changes necessary to allow the contract to operate on a fiscal year basis. IM

AT A GLANCE

According to Kiplinger Newsletter, *regulatory agencies plan to concentrate on worst offenders and go after businesses with bad records in order to get more bang for their buck. OSHA will focus on firms with many accidents, checking workers' comp files for likely culprits.*

Don't miss the Iowa Medical Society's program "When Bad Things Happen to Good People: Why You Need a Billing and Compliance Program", on December 11, which will be broadcast to 25 Iowa sites over the Iowa Communications Network. With all the post-payment audit activity in Iowa, you can't afford to miss this program. For more information about the site closest to you, see the insert in this month's Iowa Medicine.

Practice Management Workshops for You

Patient Brochures & Handbooks "How To" Workshop

Thursday, November 21 — **Ottumwa Regional Health Center, 10 a.m. – 2 p.m.**

Patient brochures have an increasingly important function both in creating an impression of your practice and in providing information to your patients. Call Sherry Johnson if you are interested in scheduling this workshop in your area.

1997 CPT Update

Dec. 2 — **Finley Hospital, Dubuque, 6 – 8:30 p.m.**
Dec. 3 — **Mercy Educ. Ctr, Cedar Rapids, 8:30 – 11:30 a.m.**
Dec. 3 — **Allen College, Waterloo, 2:30 – 5 p.m.**
Dec. 4 — **IMS hdqtrs, West Des Moines, 9 – 11:30 a.m.**
Dec. 6 — **St. Luke's Aud., Sioux City, 12 – 2:30 p.m.**

An overview of new 1997 CPT codes and changes in existing codes. Instructor: Barbara Cannon

For more information or to register for any IMS practice management workshop, call Sherry Johnson at IMS Services, 515/223-2816 or 800/728-5398.

MIDWEST MEDICAL INSURANCE COMPANY FOCUS ON RISK MANAGEMENT

Errors in Dictation

Physicians often question the need to review their dictation after it has been transcribed. The most important reason to review dictation is to prevent patient injuries. However, many dictation errors are not caught until the patient is injured or the physician is sued for malpractice.

A physician dictated a prescription for Methotrexate and the dosage was transcribed as 660 mg., instead of 66 mg. The patient nearly died. Another physician who failed to catch the "left" versus "right" dictation mistake operated on the wrong kidney.

In another case, a patient alleged a physician failed to properly reduce a dislocated finger joint, claiming the physician worked on the wrong joint. The physician was certain that the dislocation was appropriately treated, but in reviewing the dictation, the physician realized that the wrong joint was identified throughout the treatment notes. The transcriptionist had typed "DIP" instead of "PIP". The errors supported the patient's claim that the "wrong joint" was treated, even though the physician protested it was only the dictation—not the treatment—that was erroneous.

Most physicians state they are too busy to read their dictation and may use a "dictated but not read" stamp thinking this will excuse them from errors or omissions in their notes. On the contrary, not reading your dictation or using a stamp allows the patient to allege the physician was "too busy" in general to provide quality care.

For more information contact Lori Atkinson, MMIC risk management supervisor, Midwest Medical Insurance Company, West Des Moines Office, PO Box 65790, West Des Moines, Iowa 50265; 800/798-9870 or 515/223-1482.

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New IMS executive has strong legislative background

Michael Abrams has been chosen as the new Iowa Medical Society executive vice president, and he brings a strong background in legislation and public policy to the post.

He began his career as an intern in the Indiana House of Representatives Republican Caucus, where he did research and wrote speeches. In 1987, the Indiana State Medical Association retained him as a lobbyist; within two years, he had been promoted to chief lobbyist responsible for coordinating all of ISMA's government relations activities.

One year later, he was promoted to director of ISMA government relations and marketing, a post he held until accepting the IMS job.

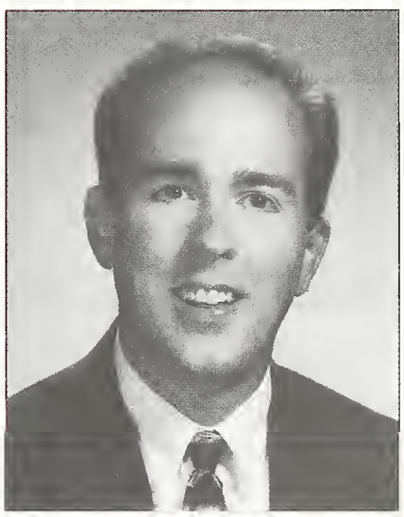
Fast Facts on Mike Abrams

BORN — Columbus, Ohio

EDUCATION — Bachelor of Arts; Masters in Public Affairs, Indiana University

FORMER POSITION — Director of Government Relations and Marketing, Indiana State Medical Association (ISMA)

CAREER EXPERIENCE — Speech writing for Republican Caucus and Indiana legislators; lobbying in state legislature; ISMA membership recruitment; collaborative outcomes data project with Indiana Hospital Association; Board of Directors, Indiana Citizens Against Lawsuit Abuse



His duties included managing a 12-person department responsible for government relations, membership recruitment and retention, physician practice management consulting and data projects. He also has experience in dealing with the media regarding ISMA legislative activity.

Abrams has a masters in public affairs from Indiana University.

"I am enthusiastic about the opportunity to serve Iowa physicians," says Abrams, who begins his new job November 11. "I look forward to participating in the leadership of an organization with such a rich history of service to Iowa physicians, patients and policymakers."

Abrams was hired by the IMS Board of Trustees after an extensive search process which began last April.

"These are challenging times for Iowa physicians," comments Dr. William McMillan, IMS president. "The Board is confident that Iowa physicians will benefit from Mr. Abrams' leadership and experience in health policy."

Mike's interests outside his profession include reading, golf, camping, music and traveling. IM

Wife of new IMS executive vice president is a physician

When Mike Abrams arrives to take over the reins as the Iowa Medical Society's new executive vice president, one of the first solicitations he receives may be from those in charge of membership in the IMS Alliance.

Mike's wife is pediatrician Mary Ann Sprauer Abrams, MD. Dr. Abrams has been practicing with the St. Vincent Hospitals Primary Care Center in Indianapolis. A native of Dayton, Ohio, Dr. Abrams had never been to Des Moines before her husband came to interview for the Iowa Medical Society job, but said it reminds her of her hometown.

Dr. Abrams earned her MD at Ohio State and has a masters from the Harvard School of Public Health. She is in the process of searching for a position in the Des Moines area.

The couple has one daughter, Elizabeth, age 14 months.

Newsmakers

Awards, appointments, etc.

Dr. Thomas Gellhaus, Davenport obstetrician/gynecologist, recently travelled to Sabana Grande, Dominican Republic where he served as a medical missionary through Medical Missionary International. **Dr. Ann Kandis**, family practice, recently joined the medical staff at Genesis Medical Group in Bettendorf. **Dr. Samuel Porter**, vice president and chief medical officer for North Iowa Mercy Health Center in Mason City, has retired. **Dr. Charles Grant** has joined Iowa Diabetes & Endocrinology Center in Des Moines. **Dr. Douglas Parks** has relocated his plastic and reconstructive surgery practice to the Lakeview Medical Park in West Des Moines. **Dr. Michael Toth** has joined the medical staff at North Iowa Mercy Health Center as the medical director for HealthWorks, Occupational Health Services. **Dr. John Chapman** of Dubuque Internal Medicine has retired from internal medicine practice. **Dr. Sonia Sather**, family practice, has joined Mercy Family Care, Forest Park in Mason City. Sioux City neurologist **Dr. Christopher Hughes** was the principle writer of all 10 cases featured in the neurology section of the 1996 medical textbook *Diagnostic Strategies for Internal Medicine, A Case-Based Approach*. The book will be used by physicians in resident training. **Dr. William Riesen** recently joined Internal Medicine, PC of Ottumwa. Dr. Riesen completed his residency and internship in internal medicine at the University of Michigan Medical Center in Ann Arbor. **Dr. John Tinker**, UI Hospitals and Clinics, Department of Anesthesiology, recently was interviewed on National Public Radio as part of a sesquicentennial series on the advent of ether. The Iowa Chapter of the American Academy of Pediatrics, with President **Dr. Julianne Thomas** of Pediatric Center, PC, has received the Outstanding Chapter Award for medium-sized chapters. The last time the Iowa Chapter won the award was in 1980; it was last nominated in 1991. **Drs. Brian** and **Gina Moran** and **Dr. Mark Hermann** have joined Dubuque Internal Medicine. **Dr. Ronald Roth**, Waterloo family practitioner, has received a Professional Service Citation from the Federal Aviation Administration (FFA) for being an aviation medical examiner for 26 years. Dr. Roth received the award at an FFA seminar in Minneapolis in August. A manuscript written by ophthalmologists **Dr. Lisa Brothers Arbisser** and **Dr. James Wymore** of Eye Surgeons Associates in Davenport, has been published in a national ophthalmic magazine. The article, "Visual acuity immediately following cataract phacoemulsification with subconjunctival anesthesia," is in the July issue of *Ophthalmic Surgery and Lasers*. Two IMS member physicians were among the volunteers who provided medical care through Health Volunteers Overseas: **Dr. Alfred Herlitzka**, a general and thoracic surgeon from Mason City, travelled to the island of St. Lucia in the British West Indies. **Dr. Rick Wilkerson**, a Spencer orthopedic surgeon, travelled to Bhutan, a small country bordering India and China. Two Des Moines family practice physicians have retired from the Mercy Hospital staff: **Dr. Roy Overton II**, who has been with Mercy since 1957 and **Dr. Mary Patricia Phelan**, who has been with Mercy for 46 years. **Dr. Judy Kim** has joined Eye Surgeons Associates, PC in Davenport. **Dr. Joseph Lohmuller**, Davenport general surgeon, has been appointed by the Iowa Department of Public Health to serve on the System Evaluation and Quality Improvement Committee for Iowa's new Trauma System. **Dr. Laura Hemann**, formerly of Dubuque Radiology Associates, PC, has begun practice in Cedar Rapids. **Dr. David Puk** recently joined the Fuerste Eye Clinic in Dubuque.

AT A GLANCE

Dr. Jerry Lewis, president of the Iowa Psychiatric Society, was quoted in the September 20 issue of Psychiatric News, Newspaper of the American Psychiatric Association. *Parts of Dr. Lewis' "President's Letter" from the summer issue of the* Iowa Psychiatrist *were reprinted.*

Rep. Greg Ganske has been honored by the National Association of Children's Hospitals for his leadership in advocacy for children's health. Dr. Ganske accepted the award at a breakfast at San Diego's Children's Museum in August.

Deceased members

Lyle Frink, MD, 78, life member, family practice, Spencer, died January 11, 1996

Walter Hanson, MD, 81, life member, obstetrics and gynecology, Edina, Minnesota, died February 14, 1996

Alan Swearingen, MD, 59, family practice, Bettendorf, died September 10, 1996 IM

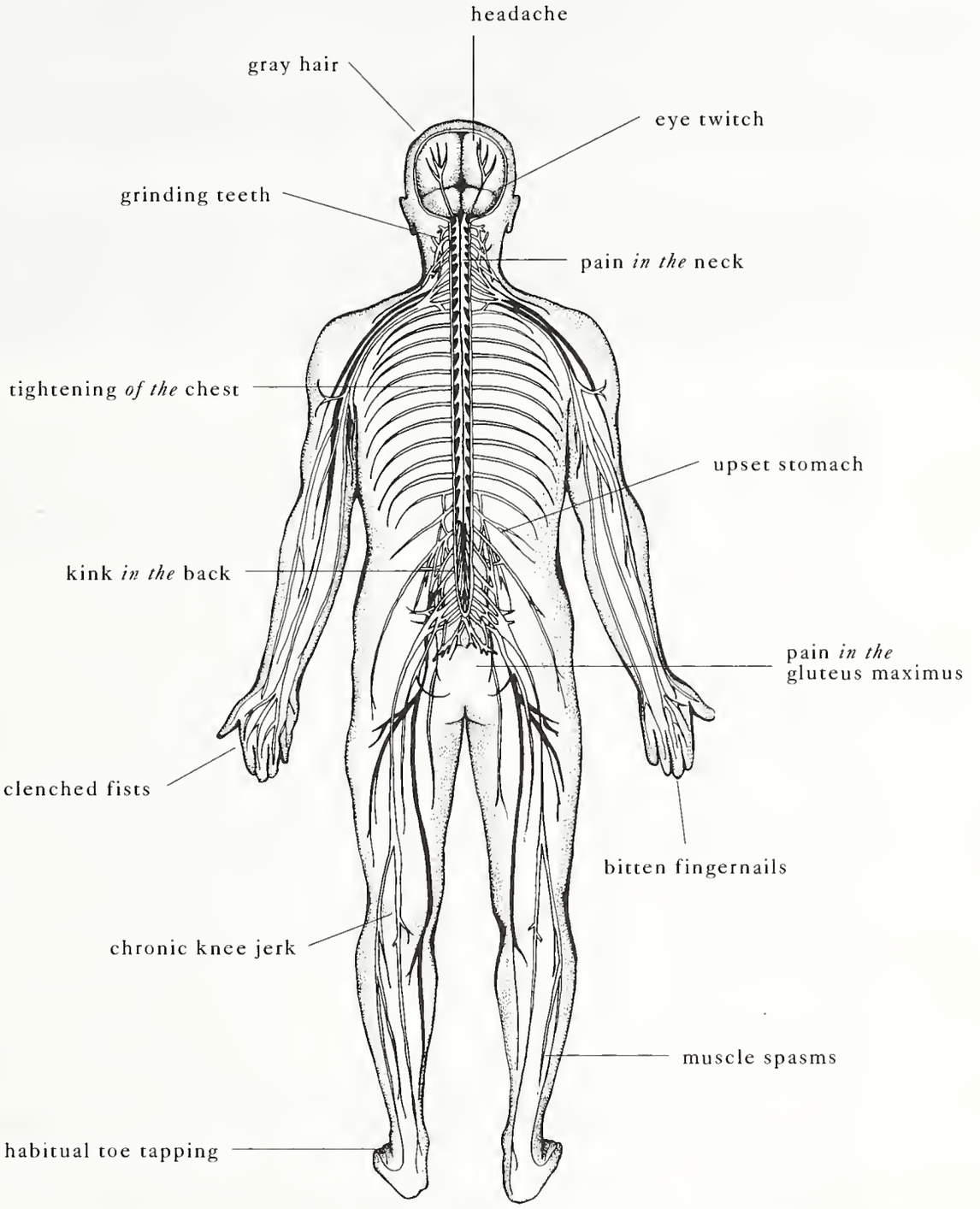


Figure 23

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Huston reflects on medicine in Iowa, long career with IMS

Medicine and health care delivery have seen many changes since Eldon Huston became executive vice president of the Iowa Medical Society. On the eve of his retirement, Eldon reflects on his career and his philosophy of leadership — work with everyone who affects the practice of medicine.

Q. Before you became involved in organized medicine, what were your other career possibilities?

A. My first job out of college and military service was with the local utility company in management training (accounting). My career path was intended to be in accounting and finance.

Q. What brought you to IMS?

A. Don Taylor, my predecessor and mentor, attended the same church plus Jodie and I rented our first furnished apartment from Don and Darlene. The accountant for the IMS was planning to retire and Don asked me at church to join him for lunch. Several months and several lunches later on March 31, 1958 I joined the IMS staff.

Q. What do you like about Iowa?

A. Iowa is my home of birth and has remained my residence except for military service in Arkansas and France. I have been fortunate enough to visit every state and several countries but Iowa is home and is the best. All the standard answers apply, great place to raise a family, friendly people, good education, bountiful land, room to really breathe and four seasons to keep one from being bored with the weather (although winters seem to get longer every year).

Q. What are the most significant changes in medicine during your 22-year tenure as IMS executive vice president?

A. The most significant changes are the dramatic advances in the science of medicine. The ability to rehabilitate, cure and improve the quality of life through medical intervention.

On the political and public affairs side, medicine has become one of the most debated and discussed social issues of the era both at the state and national levels. This has provided endless challenges to those of us who represent organized medicine.

"Its mission should be to promote the science and art of medicine and betterment of public health."

ELDON HUSTON
Eldon Huston has been executive vice president of the IMS since 1975 and will retire at the end of this year. His successor, Mike Abrams, will be interviewed in the January Iowa Medicine.



Can you afford to ignore the Internet?

Probably not. Nearly 40 million people already have Internet access, and that number is expected to grow to 300 million people in the next three years. It truly is a new form of communication that's here to stay.

Besides, you're missing a wealth of information by not using the Internet. The Internet is a 24-hour virtual library of medical resources. The Internet also allows the exchange of e-mail and real-time discussion groups for doctors and patients.

With the Internet you can research the uses of a new prescription drug or communicate with colleagues around the world about new treatments.

Now is the time to jump on the Web

If you've been thinking about getting Internet access, now is the time. The Iowa Medical Society (IMS) has launched its web site, and it's something you don't want to miss.

The IMS web site makes it easy for Internet novices to find the information they need as they explore this new medium. Experienced users discover that the IMS web site will cut down their surfing time by making resources available at a click of the mouse. We're linking IMS physicians to the information they need!

Already on the Internet?

Jump to page 4 to find out how to get your password for the IMS web site.

What is the Internet?

The Internet is a giant network of interconnected computers. Through this global network, users can send e-mail, talk to other people in discussion groups and view web sites on the World Wide Web.

The World Wide Web is the part of the Internet that allows graphics, what you generally think of as the flashy part of the Internet. The other features of the Internet, such as e-mail, are text-based.

What do you need to get connected?

To get connected to the Internet you will need a computer, a modem, a telephone line and the software to link your computer to an Internet service provider. You will also need an account with a commercial online service or an Internet service provider.

Computer: Remember that your Internet software and your current software will run at the same speed. If your computer is sluggish now, it will be sluggish in cyberspace as well.

Most Internet service providers recommend that you have 16 MB of memory and at least a 486 processor for PCs. A system with a Pentium processor works best for the Internet. Macintosh computers work best running on System 7 or higher with 8 MB of memory and 3-5 MB of disk space for applications.

Modem: The faster your modem, the better it will be for using the Internet. Modems slower than 14.4 Kpbs will be frustrating to use. If you are buying a new modem, get a 28.8 Kpbs modem.

Telephone line: You might consider getting a separate telephone line for your modem, unless you don't mind having the line tied up while you are using the Internet.

Software: You will receive easy-to-install software from the commercial online service or Internet service provider when you set up an account. Make sure you also purchase a browser program, such as Netscape Navigator or Microsoft Internet Explorer. These programs allow you to view web sites on the World Wide Web. Many Internet service providers include these programs with their software.

How do you choose a service provider?

There are two primary ways to get connected to the Internet: through a national commercial online service such as CompuServe or AmericaOnline, or through a dedicated Internet service provider.

When deciding which route to take, consider that providers don't all charge in the same way. Find out the initial set-up fees and monthly charges.

Also ask about whether you can access the service by calling a local number. If you can't call a local number, you will pay long distance phone fees for the time you are connected to the Internet.

What is best for you depends on your use of the Internet. Commercial online services are easy for new users, but they limit the number of hours you can use the service each month. After reaching that limit, you pay for additional time. Internet service providers generally have more flexible plans based on the amount of time you expect to be using the Internet.

Internet service providers

Commercial online services

These national providers offer local access numbers for most Iowa communities.

CompuServe	800/336-6823
AmericaOnline	800/827-6364
Prodigy	800/776-3449

Iowa Internet service from local telephone companies

Iowa Network Services is a consortium of local telephone companies providing local Internet access in over 300 Iowa communities. Call your local telephone company for pricing and availability of Internet access. You can also call Iowa Network Services at 800/546-6587 for the participating company nearest you.

Other Iowa Internet service providers

Over 45 other Internet service providers operate in Iowa. You can find providers in your area by looking under "Internet services" in your phone directory or by calling Melanie Finke at the Iowa Medical Society at 800/747-3070. Physicians in the Des Moines area can purchase Internet service from Healthcare Solutions Group, the company that developed the IMS web site, by calling 800/391-3713.

IMS site links you to information you need

Why is now the perfect time to jump into the Internet world? Because the IMS web site will make it easy for you. The IMS web site gives physicians daily medical news, legislative updates and medical practice advice. The IMS web site also includes links to the best medical resources on the Internet.

- Find IMS position papers, updates on activity during the legislative session and links to legislators on the "Legislation and Public Policy" page.
- The 1995 E&M utilization data for Medicare is available on the "Medical Practice and Economics" page. You can also access the Practice Management Question of the Week and coding change updates.
- Register for upcoming practice management seminars and IMS conferences on the "Events and Seminars" page.
- Read up on the latest medical and legal news from the short media clips on the "Medical News" page.
- Communicate with IMS staff by e-mail on the "About IMS" page.

This is just the beginning. We will change and add to the IMS web site to meet physicians' needs. That means we want to hear what you think about the IMS web site. To give us your opinions, just click the "Feedback" button on our site.

How do you access the IMS site?

Simply type in http://www.IowaMedicalSociety.org. Some sections of the web site are for IMS members only, so you will need to call Laura Nelson or Melanie Finke at 800/747-3070 to receive your personal password. Typing in your name and password when you are prompted will allow you to view information on the "Legislation and Public Policy" and the "Medical Practice and Economics" pages. Your practice managers or administrators can access these sections also by using your name and password.

Call IMS at 800/747-3070 for your password today!



Q. What do you see as the number one priorioty for IMS?

A. Its mission should continue to be to promote the science and art of medicine and the betterment of public health. How to accomplish that in the future is the priority.

The IMS is the voice for Iowa physicians. Its ability to implement its mission will be based on the trust it has earned and must continue to earn as it serves its physician members, their patients and the public.

We all know the medical profession is undergoing dramatic transition both nationally and in Iowa, although locally at a somewhat slower pace. As an organization, the IMS must continue to ascertain its members needs and put together strategic plans to meet those needs while maintaining the support and confidence of the profession.

Goals and strategies will change but the Mission remains the target to hit.

Q. If you could change anything about the IMS, what would it be?

A. The IMS has undergone sweeping change in the last 38 plus years and I believe it has always been willing to face change. Rather than my making a choice, I will leave that to those who remain to determine and respond.

Q. What has been the most enjoyable aspect of working at the IMS?

A The people! Physician leaders, the staff and my colleagues around the country. Few careers give you the opportunity to get to know people in all 50 states and have them as friends. I have been blessed to travel extensively and to spend time in both work and play with some of the most intelligent, concerned and fun loving individuals anyone could hope to know.

Thanks IMS!

Q. What has been the Society's biggest accomplishment during your tenure?

A. This is a difficult question to answer. What I might choose and what the members might choose could vary considerably. I

continued

MILESTONES OF ELDON'S CAREER

Iowa Medical Society — John F. Sanford Award, 1983

Iowa Society of Association Executives — President, 1984-85
Executive of the Year, 1990

Simpson College — Alumni Achievement Award, 1989

American Assoc. of Medical Society Executives — President, 1990-91

Des Moines Rotary — Board of Directors, President-elect — 1990-95

Greater Des Moines YMCA — Chair, Board of Directors, 1994-96

American Medical Assoc./EVP Advisory Committee — 10-year member

continued

would probably choose our ability to respond to the professional liability crisis in the 70s and 80s. The IMS was successful in several legislative efforts to modify tort law as it applies to this activity. Anyone who knows the Iowa legislative process appreciates the difficulty we faced.

Later the IMS assumed a major financial risk and led in the development of a professional liability company which has been quite successful. Its big role was maintaining a market in Iowa so physicians could obtain liability insurance at a cost based on Iowa experience. This has benefited both physicians and their patients by maintaining a competitive market.

"The first name that comes to mind is Mary Louise Smith. Though not an elected official, she has long been at the top of my list."

As most of you know, the Iowa liability company merged several years ago with a similar company in Minnesota and now writes coverage in North Dakota, South Dakota, Nebraska, Iowa and Minnesota.

Q. What has been your biggest disappointment during your career at IMS?

A. I am not sure there have been any big disappointments. We have lost some legislative battles but have many more victories than losses. The IMS is financially strong, respected by those with whom we work and have approximately eighty percent of the physicians in the state as members. My glass is always at least half full.

Q. You have a strong political background. Who are some Iowa politicians you admire?

A. The first name that comes to mind is Mary Louise Smith. Although not an elected official she has long been at the top of my list.

The politicians I have known and worked with both at the state and national level have reflected the Iowa culture. When I started going to Washington, Iowa had eight congressional representatives not five. Many of the names I could mention, most physicians and Iowans would not even remember.

Four that come to mind at the national level are Neal Smith and Tom Harkin from the Ds and Chuck Grassley and Jim Leach from the Rs (always bipartisan). Because of my length of service we have discussed many issues. We have not always agreed but that is politics.

I must also mention Dr. Ganske, an IMS member and congressman for the district housing IMS headquarters. We have long encouraged physicians to run for public office. Dr. Ganske should be admired for his willingness to take on such a challenge and to win. He has become an enthusiastic and effective representative for Iowa.

When I was the IMS lobbyist in the late 50s and through most of the 60s both Chuck Grassley and Terry Branstad were elected to the Iowa General Assembly. Look where they are now!

The politician I have dealt with the most is former Governor Robert Ray. This liaison has continued as he served as President and CEO for Blue Cross Blue Shield.

Q. Would you like to reflect on any of the friendships you've made over the years?

A. I mentioned friendships in response to an earlier question. I believe that is what I will miss the most.

One of my goals has always been to relate to others as a friend not an adversary. Though issues may divide us, we should try to disagree agreeably.

My philosophy is WIN – WIN. I know it has served me well and trust it has also been of benefit to the IMS.

Q. Do you have any advice to offer your successor?

A. Only when asked! IM

Year-end tax planning

Over the past few years, creative tax planning has been minimized. Some of the legislation passed in 1996 which could offer additional benefits doesn't go into effect until 1997 or later. With this being an election year, we hear every day about the proposed tax savings if we elect the right party into office. However, the bottom line for 1996 is that there is *not* a lot we can do to minimize our taxes, but the steps we *can* take are important ones. Here are my top six recommendations:

1. Defer or accelerate income to save taxes. Circumstances may provide an opportunity for lowering taxes. An example of this would be expected retirement or a lower tax bracket next year. Even if a lower tax bracket isn't a possibility, putting off the payment of taxes for as long as possible gives you the use of the money in the interim. Examples of deferring income are: 1) defer earned income by taking a 1996 year-end bonus in 1997; 2) invest excess cash in Treasury Bills that don't mature until next year; 3) structure the sale of an appreciated asset as an installment sale.

The earlier you start, the more time you have to accomplish your tax-saving goals.

2. Rev up your 401(k). Your contributions to a qualified retirement will reduce your adjusted gross income and provide other benefits such as tax deferred growth of the investment.

3. Give away appreciated stock or other assets. If you are holding some assets that have significant appreciation, why not end the year with a charitable donation of that asset instead of a cash donation? This will give you a *double* tax savings—a 1996 income tax deduction plus a capital gains tax avoidance as well.

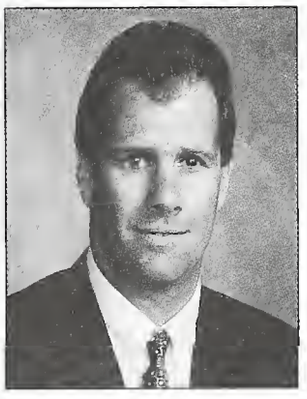
4. Maximize your deductions. Accelerating deductible expenses into the current tax year is an excellent strategy. Examples of this include prepaying state or local income taxes, prepaying any charitable contributions and making your January 1997 home mortgage payment in late December 1996.

5. Time your gains. Learn the difference between short-term and long-term gains. Long-term capital gain is the net gain on an asset that has been held for more than one year. The tax on this gain is limited to 28% or your ordinary tax rate if lower. Short-term gain is the net gain on an asset held for less than one year which is taxed at ordinary income tax rates. If you are in the top tax bracket, then the tax on a short-term gain would be 39.6%.

6. Use your losses. Ordinary losses (losses in a trade or business) are deductible in full against ordinary income (compensation, dividends, interest, etc.). Capital losses are fully deductible against capital gains. Any net capital loss (in excess of gains) may offset up to $3,000 of ordinary income per year. Any excess left over may be used in later tax years. A $3,000 write-off saves you $910 in taxes if you are in the 31% bracket.

These are only a few strategies that could generate significant tax savings. The key is to establish a plan to maximize *all* available strategies. The earlier you start, the more time you have to accomplish your tax-saving goals. IM

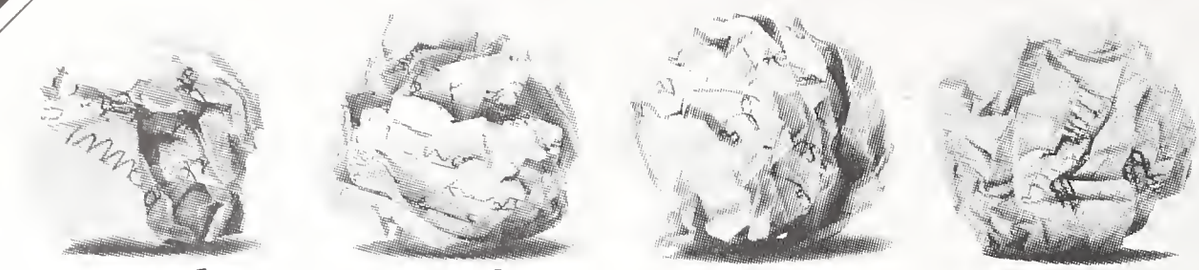
*FOR A FREE YEAR-END TAX PLANNING GUIDE, CALL JANET AT OUR OFFICE, **800/798-1012.***



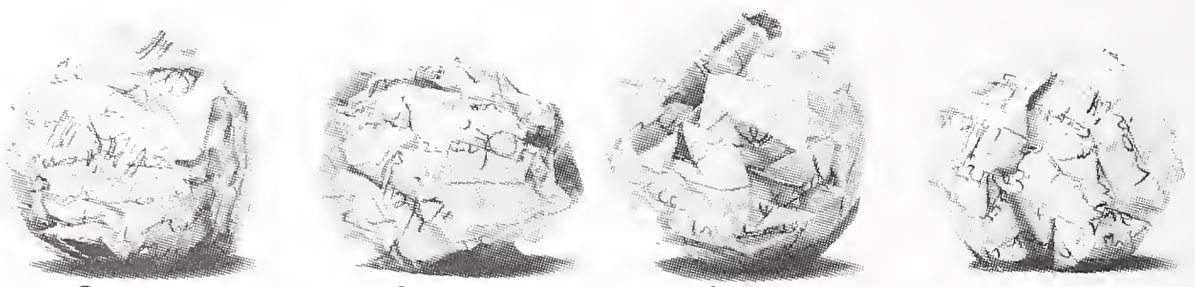
JERRY FOSTER

Jerry Foster is the founder and president of Foster Capital Management, a fee-based financial advisory firm endorsed by the Iowa Medical Society. Mr. Foster can be reached at 1-800/798-1012.

LANIER



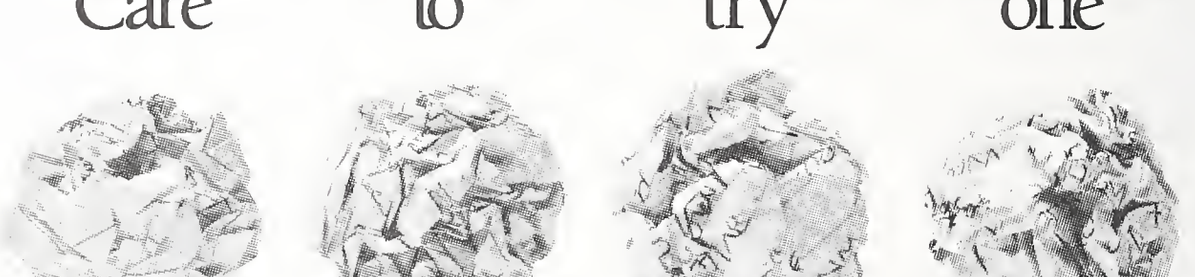
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The Journal
of the Iowa Medical Society

Microsurgical epididymal sperm aspiration

● *Jay Sandlow, MD; James Donovan, MD; Amy Sparks, PhD; Craig Syrop, MD; Brad Van Voorhis, MD; Dale Stovall, MD*

One of every five couples in the U.S. will experience difficulty achieving pregnancy.[1] The male factor is involved in approximately 50% of cases. Of these cases, 5-10% will experience difficulty due to lack of sperm.[2] This may be a result of obstruction from previous vasectomy, trauma or infection, bilateral congenital absence of the vas deferens (BCAVD) or spermatogenic failure, such as maturational arrest or Sertoli-only syndrome.

Until recently, artificial insemination by donor (AID) has been the only option available to these couples. However, newer microsurgical techniques now give many men who are azoospermic, due to obstruction, the ability to father a child.

Microsurgical epididymal sperm aspiration (MESA) is a relatively new technique that involves the harvest of sperm from the epididymis of an obstructed excurrent ductal system. With the advent and improvement of *in vitro* fertilization (IVF) techniques, such as micromanipulation, these sperm can be utilized to fertilize eggs, thus enabling couples to conceive biological children of their own.

Procedure

The procedure is indicated in men who have obstructive azoospermia due to failed vasectomy reversal, bilateral congenital absence of the vas deferens, post-infectious obstruction, or idiopathic causes. Men who are anejaculatory are functionally obstructed and may be suitable candidates as well. The procedure is not indicated in men who have non-obstructive causes of azoospermia, such as varicoceles, maturation arrest or testicular failure.

Patients are evaluated for the etiology of azoospermia preoperatively. A thorough history and physical are performed, as well as a semen analysis, post-ejaculate urine (to rule out retrograde ejaculation) and hormonal studies, including FSH and testosterone. Next, in those men without proven fertility, a testis biopsy is performed, usually under local anesthesia with sedation. This is to ensure there is complete spermatogenesis taking place within the testes, thus signifying an obstruction. We prefer to perform the biopsy under local and wait for results of permanent sections instead of utilizing frozen section, as it is often difficult to assess the complete extent of germ cell maturation in a frozen section.

In anejaculatory men, testis biopsy is optional, although if there have been repeated bouts of epididymitis/orchitis, a testis biopsy would rule out significant fibrosis of the testicle. Once spermatogenesis is confirmed, the patient is counseled regarding treatment options, including ductal bypass (if applicable), MESA or donor insemination. Patients with BCAVD are tested for one of the mutations associated with cystic fibrosis, as 60-80% of patients with BCAVD are heterozygous for at least one of these mutations.[3] Those that test positive have their partners undergo testing as well in order to better counsel the couple regarding the chances of having a child with cystic fibrosis.

Under general anesthesia, the testis is delivered through a scrotal incision. The epididymis is examined using the operating microscope and dilated epididymal tubules are identified. Typically, the most distal tubules are grossly yellow and dilated and tend to contain many white cells and degenerating sperm. As one proceeds proximally, the tubules contain clearer fluid

The IMS Education Fund has designated this article as the Henry Albert Presentation Award for November–December 1996.

Jay Sandlow, MD
James Donovan, MD
Amy Sparks, PhD
Craig Syrop, MD
Brad Van Voorhis, MD
Dale Stovall, MD
The authors are associated with the University of Iowa Hospitals and Clinics, Departments of Urology and Obstetrics and Gynecology.

Microsurgical epididymal sperm aspiration

continued

TABLE 1
RESULTS USING ICSI TECHNIQUE TO ASSIST FERTILIZATION

Motile sperm recovered	Eggs fertilized/ retrieved	Pregnancy outcome	Embryos frozen
115,000	0/2	negative	
250,000	1/14	positive, delivered	
60,000	3/4	negative	
50,000	4/6	positive, delivered	
1.6 million	7/9	negative	3
300,000	4/7	positive, delivered	
380,000	6/7	negative	2
500,000	6/15	positive, delivered	2
21 million*	6/8	positive, miscarriage @ 12 weeks	2
	6/10	positive, ongoing	2
566,000	10/21	positive, ongoing	7
18.7 million	6/10	positive, ongoing	
5.1 million	10/21	positive, ongoing	7
7.6 million	14/19	negative	11
2.7 million	12/21	positive, ongoing	8
935,000	2/4	positive, ongoing	
Total	105/191	11/16	

*Patients underwent 2 fertilization cycles

and the sperm is found to be motile.

The tunica of the epididymis is incised to expose the tubule and a glass micropipette is used to puncture the tubule. Direct micropuncture yields the cleanest specimen, as opposed to opening the tubule and aspirating the fluid. Gentle aspiration from within the tubule is performed until fluid can no longer be obtained. This is then placed in media and passed to the IVF lab personnel, where an aliquot is examined for motile sperm. Repeat aspirations are performed until no more fluid can be obtained. The procedure is usually repeated on the contralateral side to obtain the most sperm possible. In some cases the efferent ductules have been exposed and aspirated, yielding sperm of comparable quality to the epididymis. The testis is replaced within the scrotum, which is then closed with absorbable sutures.

Results

Since July 1993, we have performed 16 cycles of MESA/IVF utilizing intracytoplasmic sperm injection (ICSI) to assist fertilization. This consists of direct injection of a single sperm into the oocyte. In our early experience, the ICSI technique was still being perfected, thus yielding lower fertilization rates (4/20; 25%). However, by the third retrieval, the technique was well established, as evidenced by the highly improved fertilization rate (101/171; 59%). We have retrieved 50,000–21 million motile sperm and have fertilized 105/191 eggs (55%). Eleven of 16 patients (69%) became pregnant (Table 1). Ten of the couples that failed to conceive during their initial treatment cycle have embryos cryopreserved. All procedures were performed on an outpatient basis with no complications.

Discussion

Azoospermia secondary to excurrent ductal obstruction has been considered an untreatable condition. Despite the development and advancement of vasovasostomy/vasoepididymostomy, a significant number of men with obstruction are unable to conceive secondary to failure of these proeedures or due to unreconstructable conditions such as BCAVD. For these men, there was nothing more that could be offered until the recent advent of MESA/IVF.

One of the key factors in the success of this procedure is the expertise of the reproductive biologist. Prior to the introduction of ICSI at our program, we had performed four cycles of MESA. Although motile sperm counts of 10,000–100,000 were obtained, no fertilization was achieved. This may have been due in part to the sperm retrieval technique, as well as the micromanipulation technique used. Previous groups have examined the use of epididymal sperm with standard IVF and found that both fertilization and pregnancy rates were much lower than those now reported with ICSI.[4,5]

With the advent of MESA, new hope has been given to these couples. However, it was not until ICSI became perfected that this hope could be realized. Currently, with the small numbers of motile sperm available through MESA, significant fertilization and pregnancy rates are achievable. Future directions include isolation of sperm directly from the testicle in cases of MESA failure or for treatment of late maturation arrest.

References

References noted are available from the authors or the editors of *Iowa Medicine*. IM

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This unique insurance plan is underwritten by **Farm Bureau Mutual Insurance Company,** the company endorsed by the Iowa Medical Society for workers compensation insurance coverage. State-approved rates will enable program participants to obtain coverage on an attractive and competitive basis. Administrative support for the program is provided by IMS Services, a subsidiary of the Iowa Medical Society.

The following IMS program coverages are fixed by state law and include these benefits:

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To receive specific information about the Workers Compensation program, complete the form below or call **IMS Services:**

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WHEN BAD THINGS HAPPEN TO GOOD PEOPLE:
WHY YOU NEED A BILLING COMPLIANCE PROGRAM

WHO: Michael Reiling, Partners Consulting Group, Ltd.; David Glaser, Fredrikson & Byron

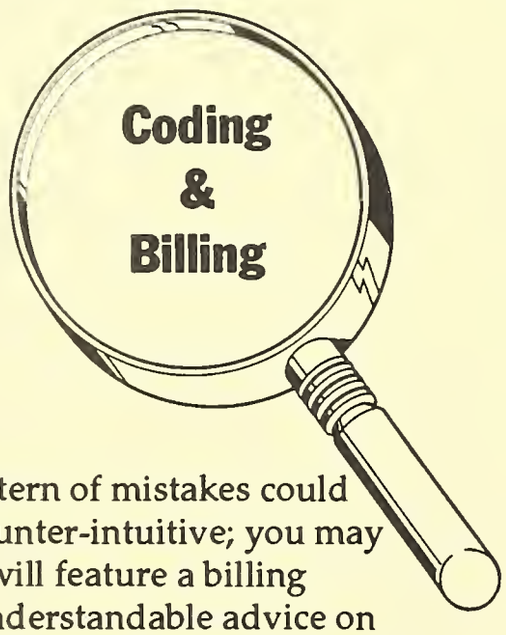
WHAT: A seminar which provides practical advice on billing rules for physicians & staff

WHEN: Wednesday, December 11, 6:00–9:00 p.m. (Dinner not provided)

WHERE: Via Iowa Communications Network (ICN) at the following sites*:

Johnston (originating site)	Iowa City
Atlantic	Jefferson
Burlington	Keokuk
Cedar Rapids	Marshalltown
Clinton	Mason City
Council Bluffs	Muscatine
Davenport	Ottumwa
Des Moines	Sioux City
Dubuque	Spirit Lake
Fort Dodge	Waterloo

*See the other side for seminar addresses for each city



WHY: A simple billing mistake can cost you a fortune and a pattern of mistakes could land you in jail. Medicare rules are often complex and counter-intuitive; you may be violating the law and not even know it. This seminar will feature a billing expert and a health lawyer who will provide practical, understandable advice on the rules that are most likely to cause you trouble. They will explain how you can establish a compliance plan that should keep you out of trouble and how to respond to any investigation of your practice if trouble ever arises.

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Originating Site	Johnston	Camp Dodge 1-Starc Armory NW 78th Avenue	
Receive/ Remote Sites	Atlantic	Atlantic National Guard Armory, ICN Room 201 Poplar Street	
	Burlington	Burlington High School, ICN Room 1421 Terrace Drive	
	Cedar Rapids*	Cedar Rapids National Guard Armory, ICN Room 10400 18th Street SW	Cedar Rapids-Prairie High School 401 76th Avenue SW, Second Floor, Next to Library
	Clinton	Clinton National Guard Armory, ICN Room 1200 13th Avenue N	
	Council Bluffs*	Council Bluffs-Lewis Central High School Hwy. 275	Council Bluffs National Guard Armory, ICN Room 2415 East Kanesville Blvd.
	Davenport	Davenport-Central High School, Annex, ICN Classroom 1120 Main Street	
	Des Moines	Iowa Methodist Medical Center, Hill Auditorium 1200 Pleasant Street Blank Children's Hospital Entrance	
	Dubuque*	Archdiocese OES, Basement, ICN Room 1229 Mt. Loretta Avenue	Dubuque National Guard Armory Bldg., ICN Room 195 Radford Road
	Fort Dodge	Trinity Regional Hospital, Conference Room #2 802 Kenyon Road	
	Iowa City	University of Iowa Pappajohn Business Administration Bldg., Room W 107 (Metered parking available in basement, enter garage from Clinton Street)	
	Jefferson	Greene County Medical Center, Public Health Classroom 1000 West Lincolnway	
	Keokuk	Keokuk National Guard Armory, ICN Room 170 Boulevard Road	
	Marshalltown*	Iowa Veterans Home, Whitehill Auditorium-North Campus 1301 Summit	Marshalltown National Guard Armory, ICN Room 9th and Summit
	Mason City	Mason City National Guard Armory, ICN Room 1060 19th Street SW	
	Muscatine	Muscatine National Guard Armory, ICN Room 1421 Park Avenue	
	Ottumwa	Ottumwa National Guard Armory, ICN Room 2858 North Court Road	
	Sioux City	Sioux City National Guard/Air Guard, Bldg. 250 3200 Remington Road	
	Spirit Lake	Spirit Lake High School, ICN Room, East Wing 2701 Hill Avenue (Back parking lot entrance)	
	Waterloo*	Waterloo AASF 2245 West Big Rock Road (Airport entrance—back side)	Waterloo National Guard Armory, ICN Room 3306 Airport Blvd. (Airport entrance)

***Note: Two facilities available in these cities**

Hats off to Iowa's earliest physicians

As we come near to the end of Iowa's sesquicentennial year, it is appropriate to note the integral part physicians played in the development of our state. A summary of the history of medicine in Iowa was published by the Iowa State Medical Society in 1950. From that publication, *One Hundred Years of Iowa Medicine*, I have gleaned some interesting facts about the physicians of Iowa during those early years.

The first territorial legislative meeting was held in Iowa City in 1841. After two years of struggle with the Union over boundary lines, as well as slavery issues, Iowa entered the Union as the 29th state on December 28, 1846. From 1832 to 1844 the population of Iowa increased from 50 to 88,000.

An account written about a military expedition across northern Iowa in 1820 tells of a Dr. Samuel C. Muir who lived with his Indian wife and two children near the lead mines south of what is now Dubuque. Dr. Muir was a graduate of the University of Edinburgh and had resigned his commission with the Army when an order directed all officers to separate themselves from Indian wives. He refused to abandon his family. Later they moved to a site near the mouth of the Des Moines River, which became the nucleus of a settlement eventually to become Keokuk.

History records that the first real pioneer physician to locate in Iowa was Dr. Frederick Andros, who came to Dubuque in 1833. Originally from Massachusetts, he graduated from Brown University in 1826. Accounts tell of his intelligence and abilities superior to the average physician. In addition to his degree in medicine, he had a degree in literature. In 1861 he moved to McGregor; and later to Dakota territory because he thought Iowa was becoming too civilized.

Two other physicians had settled in Dubuque. In 1834 Dr. Stephen Langworthy joined his four pioneer sons who opened the old lead mines discovered by Julian Dubuque in about 1788. In 1836 Dr. John W. Finley settled in Dubuque. Finley Hospital still stands as a tribute to him.

After the town of Davenport was opened for settlement in May 1836, the first physician to locate there was Dr. E. S. Barrows. For the next 1 1/2 years the nearest physicians were in Burlington and Dubuque, each town 100 miles distant. When the Scott County Medical Society was formed in 1856, Dr. Barrows was the first president; later in 1859 he became president of ISMS.

In 1863 Dr. John W. Finley settled in Dubuque. Finley Hospital still stands as a tribute to him.

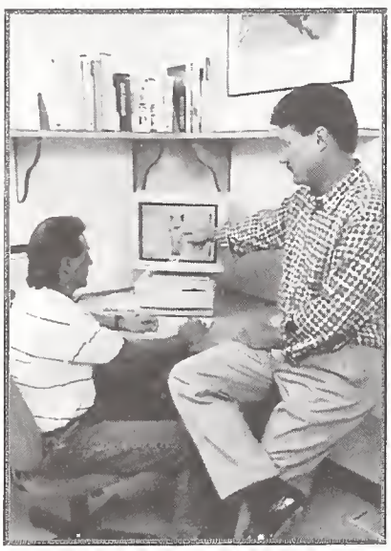
It is obvious the stronghold of medical practice in the early days of Iowa was along the Mississippi River. Later, with trade routes following the major rivers, pioneers and physicians began to move farther north and west; especially along the Des Moines River . . . Farmington, Bonepart, Keosauqua, Ottumwa. Further movement was west from Davenport to Iowa City and Cedar Rapids. From Dubuque movement progressed west and toward Minnesota. IM



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EDITOR'S NOTE: THIS IS PART ONE OF A TWO-PART SERIES TO BE CONTINUED JANUARY 1997.

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What's to be done with "bad" children?

The medical literature and the lay press are focusing increased attention on physician management of children with behavior difficulties. The children with difficulties are variously defined, but range from those children who are disruptive in the classroom to older children and youth with truancy and delinquency. A specific concern of the media has been the use of psychotropic drugs, including stimulants such as methylphenidate, in the management of children with hyperactivity and attention problems.

It is not an overstatement to say that most physicians over the age of 40 had very little education or training related to childhood behavior disorders during medical school and residency. The exposure to the issue undoubtedly was greater for physicians in the primary care specialties, but standard texts and curricula have not devoted much time to these issues until recently.

Therefore physicians in primary care practice, and certain specialties such as neurology and psychiatry, are now confronted with referrals by parents, child care staff and educators, requesting diagnosis and treatment for such children. This is one of innumerable situations where the physician must rely on knowledge and skills acquired following formal training in order to appropriately evaluate and manage these children.

The press has come to the reasonable conclusion that physicians may feel ill-equipped with this population of children and therefore resort to the prescription pad as a means of intervention. In fact, we now know that Iowa has among the highest rates of methylphenidate prescribing by licensed physicians among all states.

There is certainly no convincing evidence that disorders of children that may be constitutional (a result of altered central nervous system function) are increasing simply based on changing environment of children in young families. Alternatively, higher rates of divorce and single parenting, increasing poverty among children and greater expectations of schools may be contributing to this phenomenon.

Iowa has among the highest rates of methylphenidate prescribing by physicians.

The physician learner who is expected to provide medical services to this population of children has a variety of continuing medical education options to increase knowledge and skill. They include written materials, self-learning exercises and structure workshops and courses. Most experienced clinicians emphasize the need to work jointly with schools and community agencies to assure care management is coordinated and not fragmented.

"Bad" children are just another reason for physicians to maintain contemporary medical skills. Good practice requires familiarity with appropriate indications for medication and the rationale for recommendations made to parents and educators. IM



Richard Nelson, MD

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